

**A CALL FOR SYSTEM-WIDE CHANGE: EVALUATING
THE INDEPENDENT ASSESSMENT OF THE VET-
ERANS HEALTH ADMINISTRATION**

HEARING

BEFORE THE

**COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES**

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A CALL FOR SYSTEM-WIDE CHANGE: EVALUATING THE INDEPENDENT ASSESSMENT OF THE VETERANS HEALTH ADMINISTRATION

Wednesday, October 7, 2015

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Benishek, Huelskamp, Coffman, Wenstrup, Abraham, Costello, Radewagen, Bost, Brown, Takano, Brownley, Titus, Kuster, O'Rourke, Rice, Walz, and McNerney.

OPENING STATEMENT OF CHAIRMAN JEFF MILLER

The CHAIRMAN. The committee will come to order.

If we get somebody to close the door. Thank you, Bob.

Thanks, everybody, for joining us for today's oversight hearing called A Call for System-Wide Change: Evaluating the Independent Assessment of the Veterans Health Administration.

This morning, we are going to discuss the findings and recommendations of the independent assessment of VA's healthcare delivery system and management processes. The assessment was required last summer by the Veterans Access, Choice and Accountability Act and was intended to develop a path forward for the VA healthcare system that was then and still does continue to have difficulties.

The secretary's prepared remarks for this morning's hearing call the assessment a valuable instrument for validating the areas that require attention. And in presentation two weeks ago before the Commission on Care, Dr. Shulkin, the Under Secretary for Health, called the assessment an excellent tool.

But I see the assessment as much more than that. It is more than an instrument and it is more than a tool. The assessment encompassed a review of virtually every aspect of VA healthcare and over the course of more than 4,000 pages, it described in painful detail the numerous, significant and systemic flaws that challenged the healthcare system that is tasked with providing high-quality healthcare to our veterans.

The assessment then thoughtfully lays out what steps need to be taken to transform the broken VA healthcare system into one that

our Nation's veterans can truly be proud of. Perhaps most alarming are the assessment's finding regarding leadership.

For example, the assessment found that VA healthcare facilities are plagued by an ever-growing but ineffective bureaucracy that has ballooned by 160 percent over the last five years without resulting in any discernible improvement in business or health outcomes.

That could be because the assessment also found that VA suffers from an expanding scope of activities that has led to confusion about strategic direction and leadership priorities. It has an unnecessarily complex and fragmented organization structure characterized by a culture that is risk averse and distrustful and is run by a workforce that is steadily losing its motivation, consumed by addressing crisis after crisis and lacks a leadership pipeline that is failing to attract and train the next generation of healthcare leaders.

Sadly these findings are not new to those of us who have been working on these issues. In fact, many of them are things that those around this dais have been discussing in this hearing room for many years.

However, they are startling and they are deserving of both our immediate attention and our prolonged commitment to a sustained change, a change that will come from nothing short of a top-to-bottom transformation and a willingness to have difficult conversations about VA's true mission and should be in support of our Nation's veterans.

Unfortunately, rather than detailing VA's plan for systematically implementing the recommendation of the assessment and deviating from the status quo that is harming our veterans, the testimony that we will be hearing today repeats a lot of the same talking points that we have heard in the past.

For nine pages, VA provides little in any way of concrete details about what, if any, specific actions VA is taking as a result of the assessment and how we as a committee can assist the VA in its efforts.

But VA does take time in their testimony to repeat misleading talking points from May regarding House passed fiscal year 2016 budget equating it to a VA medical care budget cut and claiming it would result in 70,000 fewer veterans receiving care.

Both of those allegations are untrue as the Washington Post fact checker pointed out earlier this year. In fact, the VA budget that the House has proposed represents an increase in VA's discretionary budget and would continue the trend of budget increases that have led to a more than 70 percent increase in the bottom line over the last six years.

I appreciate the secretary being here today taking time out of his schedule, but we both can agree that we each can do better and make more out of the assessment that is before me today if we avoid retorting to disingenuous talking points and instead focus on the hard work that lies before both of us.

Our veterans cannot afford to let this assessment become just number 138 gathering dust on some shelf locked away where nobody else will see it again.

And before I yield to the ranking member, I would like to take a moment to thank the MITRE Corporation, the RAND Corporation, the Institute of Medicine, McKinsey & Company and Grant Thornton for their efforts in completing this assessment.

I am also grateful for the efforts of the members of the Blue Ribbon Panel who selflessly lent their expertise as well. Thank you all for your hard work. I guarantee that our hearing today is just the start of this committee's work regarding the many thoughtful findings and recommendations that this group has laid out for us.

**OPENING STATEMENT OF RANKING MEMBER CORRINE
BROWN**

And I recognize the Ranking Member, Ms. Brown, for her opening statement.

Ms. BROWN. Thank you, Mr. Chairman.

Before I begin my statement, Mr. John E. Arnold is here. He is a Vietnam veteran and he came all the way from Jacksonville. I would like for him to stand because this hearing is all about veterans.

Sir, would you just stand? Thank you for your service. Thank you.

Last year in the Veterans Access, Choice and Accountability Act of 2014, we mandated that there be an Independent Assessment of Veterans' Healthcare. This morning's hearing is on the results of that Independent Assessment.

The Assessment highlights many of the things we hear from our veterans. We hear that the VA provides excellent healthcare, especially healthcare related to the special needs of the veterans. We also hear that in certain areas, VA is the forefront of healthcare in this country.

We also hear from our veterans that VA care is often fragmented and that it can be difficult to navigate and arrange non-VA care. We hear of long waiting times and limited access.

For us on this Committee, the results of this Assessment are not new. Over the years, and for me, it's 23, we have seen a system become mired in bureaucracy and be required to do more when sometimes the resources to do more have not been made available.

What the Independent Assessment provides us is a detailed, thorough and fair look at where the Veterans Healthcare Administration is and the steps that we must all take to get it back on the right track and focused on veterans.

What is clear is that if we are to meet our promise to our veterans, we must begin to look at reform. This reform must enable VA to focus on healthcare and operate, like the Secretary has previously stated, as a business. And the business of the Veterans Health Administration must be a clear and unwavering focus on the veteran patient.

The Independent Assessment points out that piecemeal fixes and legislation targeted at only one issue will not cut it. VHA needs a complete overhaul from the way it schedules and delivers care to patients, to the way it treats its employees and I want to point out, the way it partners with community providers.

It is approaching two decades since VHA last underwent a major reform effort. We must now begin the work of ensuring that VA

healthcare is poised to meet the challenges of healthcare today, and the Independent Assessment will help us in that endeavor.

I look forward to hearing from the Secretary as to what steps he has taken to begin the reform process, and to hear from our other witnesses on to how we can work together to ensure that healthcare for our veterans receive is the very best.

Thank you, Mr. Chairman, and I yield back the balance of my time.

[THE STATEMENT OF RANKING MEMBER CORRINE BROWN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Ms. Brown.

We are joined this morning by the Honorable Robert McDonald, Secretary of the Department of Veterans Affairs, better known to many people as Bob. Secretary McDonald is accompanied by the Honorable David Shulkin. He's the Under Secretary for Health.

Dr. Shulkin, thank you for being here, too.

We are joined by Richard Byrne, Senior Vice President of the MITRE Corporation, the independent assessment program integrator, and by Dr. Giroir who is Senior Fellow of the Texas Medical Center Health Policy Institute and the chairperson of the independent assessment Blue Ribbon Panel.

Mr. Secretary, we appreciate you being here. Two things before we begin. Thank you for allowing us to compress into a single panel instead of doing two panels today and, secondly, your staff had asked for a ten-minute opening statement. But because of time and many of the questions that members have today, I have asked that you restrict your comments to five minutes so that we can ask the questions. All members can avail themselves to the secretary's written comments that are in the binder before you.

So, Mr. Secretary, you are recognized for five minutes.

STATEMENTS OF ROBERT A. MCDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY DAVID J. SHULKIN M.D., UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS; RICHARD J. BYRNE, SENIOR VICE PRESIDENT, THE MITRE CORPORATION; BRETT P. GIROIR M.D., SENIOR FELLOW, TEXAS MEDICAL CENTER HEALTH POLICY INSTITUTE

STATEMENT OF ROBERT A. MCDONALD

Secretary MCDONALD. Chairman Miller, Ranking Member Brown, members of the committee, I am pleased to be here with Dr. David Shulkin, Under Secretary for Health, to talk about the independent assessment and all that VA is doing to improve the veterans' experience at VA.

I think this is the most important hearing that we have had since I have been secretary because it is the first hearing that we have had on the transformation of VA.

For the most part, the assessment which, as you know, started over a year ago confirms our own analysis and I am pleased to say we have already started taking action. The assessment had a great deal of information on known problems, but also had some new ideas that we are incorporating into the transformation we are doing.

One aspect of the assessment's findings and recommendations deserves special emphasis and that is the misalignment of requirements and resources. We know now that the access crisis of 2014 was mostly a matter of growing demand for VA healthcare overwhelming our capacity for supply.

For example, we have a requirement that all disability claims should be adjudicated in under 125 days and we have made outstanding progress in meeting that requirement. We have cut the backlog of those claims from 611,000 in May of 2013 to less than 75,000 today, but we have done that by having our workers, our VBA workers work mandatory overtime for over four years.

We have incrementally put more people in the budget each year that had been stripped out. We obviously need more people if we are going to be able to get these claims down to zero. So this is a classic case of where the 125-day requirement and the budget that we have been given don't match and we can't have people working overtime forever.

I take issue with one of the assessment's recommendations and that one is that Congress establish a governance board to, and I quote, "develop fundamental policy, define the strategic path, insulate VHA leadership from direct political interaction and ensure accountability for the achievement of established performance measures."

I believe this is the role of this committee and the Senate Veterans' Affairs Committee working collaboratively with the department and me. We have proven that VA can make changes needed to provide veterans with the care and benefits they deserve. All we need to do is have your support and work together to do so.

At the enterprise level, my VA transformation is well underway providing both short-term and long-term support for effective responses to many of the assessment's recommendations.

As you know, we have five strategies. First is improving the veteran experience. Second is improving the employee experience. Third is achieving support service excellence. Fourth is establishing a culture of continuous improvement and fifth is enhancing strategic partnerships. And we would be happy to drill down on those during the question period.

We are also implementing VHA's blueprint for excellence detailing how VHA will evolve as a model healthcare provider. It is designed to improve access to healthcare, create a personalized experience for each veteran and bring VHA's performance measures and reporting requirements in line with those in use throughout the healthcare industry.

In the past year, we have moved out aggressively in response to the access crisis meeting increasing demand and expanding capacity on four fronts, more staffing, more space, more productivity and more VA care in the community.

During that period of time, we have completed seven million more appointments for veterans of completed care, four and a half million in the community, two and a half million within VA. We have added more space. We have added more providers. We have added more extra hours, all in effect to get more veterans in.

But because of that and because we have done a better job of caring for veterans, we have more veterans desiring care. So even

though 97 percent of appointments are now completed within 30 days of the needed or preferred date, the number not completed in 30 days has grown from 300,000 to nearly 500,000.

This brings us back to the fundamental problem, the imbalance of supply and demand and the need of congressional action. So let me get to what we need.

The House proposed \$1.4 billion reduction of the VA's budget request would mean \$688 million less for veterans' medical care and a 50 percent cut in VA's construction budget. A 50 percent cut in the construction budget at a time that our facilities, 60 percent of our facilities are over 50 years old doesn't make any sense.

Second, we need Congress to give us the flexibility to align resources with veterans' demand for care as the independent assessment suggested.

Third, we need Congress to act on the proposal we submitted May 1st and the uncertainty about aspects of purchased care that are outside the Veterans Choice Program and that complicate provider participation and VA's other care in the community programs.

Finally, we need Congress to address the many statutory issues that burden VA with red tape and bureaucracy. This is a problem almost everywhere in VA. We simply can't make many necessary changes because of statutory limitations.

We need to consolidate our various care in the community programs. We need a freer hand to hire, assign and reward the executives we task to act as change agents. We need a freer hand in disposing of outdated, unused or little used facilities. We need a freer hand in the management of existing facilities so facilities' managers can adjust their use of resources to the changing needs of veterans.

Bottom line, we at the VA are working hard to do our part. We have moved out smartly to aggressively tackle issues within our control. We have also demonstrated tremendous readiness and ability to effect fundamental organizational change.

My VA is already making a difference in the veterans' experience of VA. Maybe some day we could hold a hearing on the My VA transformation. I would welcome that. But we can't continue making progress without reconciling requirements and resources and we can't reconcile requirements and resources on our own. We need your help to do that.

Veterans and the American people expect us to work together on their behalf and we look forward to doing so.

[THE STATEMENT OF ROBERT A. McDONALD APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Mr. Secretary.

We intend to work with you and we will look at some of those issues that you have just raised. And I have got a couple questions I am going to ask you in just a few minutes as well in reference to legislative solutions and suggestions.

Mr. Byrne, you are recognized for your testimony for five minutes.

STATEMENT OF RICHARD J. BYRNE

Mr. BYRNE. Chairman Miller, Ranking Member Brown and distinguished members of the committee, thank you for the opportunity to appear before you today.

My name is Rich Byrne and I represent the MITRE Corporation and our partners as the senior executive responsible for conducting the independent assessment as required by Section 201 of the Veterans Access, Choice and Accountability Act of 2014.

Now, before I get into the details, I would like to acknowledge the many, many individuals, men and women throughout VA who are deeply committed to the welfare of our Nation's veterans and who unselfishly supported the assessment in every way they could.

We saw no hesitation for them to help us in any way. It was a privilege for every one of the team members to work on the assessment of this historic organization and on the Nation's most complex healthcare system.

Our assessment was conducted in partnership with the RAND Corporation, McKinsey & Company and Grant Thornton and supported by an independent Blue Ribbon Panel composed of 16 top healthcare experts who reviewed our work to ensure that it incorporated the very best practices of the private sector.

The assessment team visited 87 facilities, analyzed over 19,000 documents and data sets and reviewed 137 previous assessments and conducted over a thousand VA interviews. We spoke with ten veteran service organizations and 27 U.S. healthcare organizations.

Our assessment presents a broad, independent and evidence-based set of findings and recommendations. While overall VHA quality of care was comparable to private sector and had pockets of excellence, we found large variations in performance that resulted in too many unacceptable veteran experiences.

This lack of consistency we believe was due to four pervasive, systemic issues. Under governance, there was a disconnect in the alignment of demand, resources and authorities.

Under operations, there were uneven bureaucratic processes that were too often provider-centric, not patient-centric. And under data and tools, there were too many variations of non-standardized data and non-interoperable tools.

And, finally, under leadership, leaders were not fully empowered due to a lack of clear authority, confusing priorities and a culture of distrust.

In reviewing the past 137 assessments of VHA, we found a number of findings that persisted year after year despite heroic efforts to resolve them. We concluded that these individual findings addressed individually did not then and will not now, result in sustainable or scalable solutions.

It is our belief that the only way to successfully transform VHA in an enduring manner is to address all of these systemic issues using an integrated systems approach. A systems approach would simultaneously build on improvements in all four of these four systemic areas in an integrated and consistent manner independent of which finding we are going to address.

Each solution would then build upon the previous solutions to increasingly improve the underlying root causes of the system that

allows these anomalies and variations to happen. This will result in a sustainable and scalable solution.

Taking the whole system perspective also supports reframing problems within a larger context which in turn can lead to radically different, even transformational solutions with the potential to provide much greater value than simply improving the status quo.

For example, if a hospital's construction is overrunning, in addition to looking at funding increases, it is critical to assess the four systemic cornerstones. Let's take an example of that. On the data, using accurate data, what is the veteran demographic demand for that hospital in that local area? Applying appropriate governance for purchased care options for the private sector, do we have to build the entire hospital for that demand or is there excess capacity in the private sector?

To streamline operations, what are the national productivity standards that should be targeted? And from leadership, how will healthcare be delivered in the future to incorporate trends like telehealth?

Taken all together, these four cornerstones make you look at the problem of funding a specific facility in a bigger light. What is the future hospital that VA needs to build, not the one of the past?

Together these four system perspectives is what we believe to be the secret to having enduring, scalable, sustainable solutions.

Now, as one private sector doctor said, VHA is strong in anatomy but weak on physiology. So what that means is it is clear that VHA has all the parts necessary to be a world-class provider.

However, for all these parts to work smoothly together, it will take a significant transformation to build the collaboration inside and outside of VHA, to create patient-centered operations led by empowered leaders who are informed by the right data and tools with the appropriate governance and resources to deliver our Nation's promise to our veterans.

Thank you very much.

[THE STATEMENT OF RICHARD J. BYRNE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much.

Dr. Giroir, you are recognized.

STATEMENT OF BRETT P. GIROIR

Dr. GIROIR. Chairman Miller, Ranking Member Brown, members of the committee, thank you for the opportunity to be here today.

My name is Dr. Brett Giroir and I am honored to serve as chair of the independent Blue Ribbon Panel created by MITRE to provide support, oversight and guidance for this independent assessment.

The Blue Ribbon Panel was composed of 16 distinguished and outspoken independent experts whose names and biographies are listed in the integrated report. But briefly the panel included the former CEOs of Kaiser Permanente, Geisinger, Healthcare Partners and the California Healthcare Foundation, the former executive VP of United Health, the physician and chief of Mass General Hospital, the former surgeon general of the Army and vice chief of the Army, the world's leading academic experts in organization change and health innovation, the CEOs of the National Quality

Forum and the Texas Medical Center, the dean of the Jefferson College of Nursing, a board member of the National Patient Centered Outcomes Research Institute and a former director of Medicare and Medicaid services.

Each Blue Ribbon Panel more importantly shared a deep commitment to our veterans and nearly all had direct personal or family experiences with the VHA. Ultimately the panel members unanimously endorsed the integrated report and its findings and recommendations.

The report contains numerous near-term operational recommendations, few of which were unexpected by anyone in this room. For example, enhanced physician productivity, a key element of enhancing access will require more exam rooms, increase clinical support staff, improved patient scheduling and greater authority granted to clinic directors for overall resourcing.

But more importantly, the report also offers recommendations to solve deeper root-cause issues that have persistently plagued the VHA and have prevented the successful implementation of reforms that were already suggested by the 137 previous VHA assessments.

As Mr. Byrne has already testified, these root-cause issues are the basis for four overarching recommendations in the area of governance, leadership, operations and data and tools.

Indeed, even the example I just gave of improving physician productivity appears straightforward, but would require reform of unnecessarily bureaucratic clinical staff hiring processes which take three times as long as the private sector, empowerment of VA medical center leadership to flex resources to meet dynamic patient access needs, commitment to a modern electronic scheduling system that transparently indicates appointment availability to both schedulers and patients alike and overhaul of the facilities' construction leasing processes that now cost twice as much as the private sector but proceed at a pace that is two to three-fold slower.

I would also emphasize that one of the most urgent strategic priorities is to establish and clearly communicate the future mission of the VHA and for Congress to align resources and authorities to achieve that specific mission.

As background, in 2014, 9.1 million of 21.6 million U.S. veterans were enrolled in the VHA. Of these, 5.8 million were actually patients and on average, these patients rely on the VHA for much less than 50 percent of their healthcare services.

These demographic data combined with access challenges suggest reconsideration of whether the VHA should aim to be the comprehensive provider for all veterans' health needs or whether the VHA should evolve into more focused centers providing specialized care while utilizing non-VHA providers for the majority of veterans' healthcare needs.

Either paradigm could be highly beneficial to veterans as long as the demand and resources are prospectively aligned and there is a consolidation of current programs to simplify access to non-VHA providers.

I also want to emphasize that although the report clearly outlines significant and long-standing problems, there are shining examples of emerging best practices at the VHA regional level that

have improved access and quality and begun to change the overall organizational culture.

Finally on behalf of the panel, I would also like to express our appreciation to the hundreds of experts who contributed to this report and to the literally thousands of contributing veterans and VHA employees who believed that this report would become a road map to achieve the highest quality of care for veterans.

I would also like to express our gratitude to this congressional committee for your support of veterans and our panel and for the opportunity to answer any questions related to our assessments and recommendations.

Thank you.

[THE PREPARED STATEMENT OF BRETT P. GIROIR APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Dr. Giroir.

I would like to begin the questioning with you on a point that you just brought up in both your written and your spoken testimony about the demographic data that the assessment collected. And I think that is a question that has been raised in this hearing room many times over the last year and a half.

So I would ask you given the choice of the two paradigms that you have discussed, one of which where VA aims to be a comprehensive provider of care for veteran service-connected and non-service-connected care needs or one in which VA functions as a coordinator of care focused primarily on being a center of excellence for specialized care, which do you think that VA should pursue and why do you think the way you do?

Dr. GIROIR. Okay. Well, this certainly is one of the key questions. The Blue Ribbon Panel clearly made a recommendation that veterans' healthcare within each region needs to be evaluated by assessing both the VHA capabilities and the non-VHA capabilities and that is clearly trending.

The use of non-VHA providers both when care is unavailable or when it is more readily available is something that needs to continue and probably needs to expand.

The Blue Ribbon Panel did not make an assessment of those two alternatives in the extreme, but clearly focuses on the ability to expand integration with the private sector because the VHA is no longer a siloed institution. It is part of an integrated healthcare network.

And the veterans are telling you that with their voting. They are voting with their feet. Less than 50 percent of their healthcare even among VHA patients are received from the VHA and as little as 15 percent of their outpatient appointments come from the VHA. So they are telling you that an integrated approach with the commercial sector is desirable and beneficial.

The CHAIRMAN. Dr. Shulkin, could you comment just a little bit? I know it is at odds with the VA's approach, but do you differ from Dr. Giroir's assessment in regards to people voting with their feet?

Dr. SHULKIN. Thank you, Mr. Chairman.

I don't think that this differs from the VA approach. The VA approach is to find the very best care that serves the veterans. And I think that we have shown that in response to our access crisis

that we have encouraged the use of community care to address our access issues.

I think the difference here between maybe what—I would expand on what Dr. Giroir said is that the care that VA provides is very, very different than the care that the private sector provides. The VA provides a much more comprehensive approach than just dealing with physical illness issues. It provides psychological and social aspects of care that actually meet the needs of what veterans require.

And that is why I think that we really do need to do what Dr. Giroir said which is to see what VHA provides best for our veterans and what care can be provided by the private sector. And it is that hybrid type system that is going to meet our veterans' needs.

The CHAIRMAN. So, Mr. Secretary, when you talk about the House-passed budget being a cut effectively taking away healthcare from 70 plus thousand veterans, is that not what we tried to solve back last year with the Choice Program where we gave billions of dollars to provide—if you couldn't provide it inside the VA, you could provide it outside? So something doesn't match with the continued statement that the House passed budget is a cut that will harm veterans' healthcare.

Secretary McDONALD. Mr. Chairman, as Dr. Shulkin said, we are in favor of a hybrid system that takes advantage of all of our partners. Even before the Choice Act, we had many veterans who were going to our medical school affiliates, who were going to the Alaska Native Health System, who were going to the Indian Health System, who were going to joint DoD/VA facilities. We are totally in favor of that.

Right now in Fort Benning, for example, in Columbus, Georgia, we have got veterans going to Martin Army Hospital for 18 specialties that the VA doesn't provide. We are totally in favor of that. But here is the issue. As Dr. Giroir mentioned, veterans today we estimate use the VA for only 34 percent of their healthcare. Every percentage point that they decide to use the VA more, that means we need an increase in budget of \$1.4 billion.

The federal budgeting process is not dynamic enough to take advantage of that. And what we have got is veterans coming to VA because the care is better. In fact, a recent VFW study showed that 82 percent of veterans prefer the VA and showed that 87 percent of veterans recommend the VA.

So as that 34 percent gets higher, we have got to have the money to care for those veterans. When we put together the budget for 2016, we put together a budget that we thought would meet demand if we got the total budget amount and, as you recall, if we got budget flexibility to move money from one of the 70 line items to the other, that we don't have that flexibility today.

So this wasn't a question of trying to put money in coffers or in a bank. This is the demand that we see. And if we don't get that money, we won't be able to meet the demand at the requirements that we have.

Importantly in my statement, I said if we want to work together to change the requirements, for example, 30 days appointments,

maybe it doesn't need to be within 30 days, that's fine, but we have got to match requirements and budget at the same time.

The CHAIRMAN. Well, I would remind you that the 14 day and the 30 day were dates that VA set, not us. So——

Secretary McDONALD. As you know, we have eliminated the 14 days.

The CHAIRMAN. I know. You know, if you need to change for budgetary reasons, I would understand that. You are also talking about increasing and requiring \$1.4 or 5 billion. That number could also decrease as well.

And I would tell the members here that the cut to the President's request, quote, "is less than what we added to finish the Denver project."

And with that, Ms. Brown, you are recognized.

Secretary McDONALD. Mr. Chairman, remember the cut also included a reduction in construction by 50 percent at a time when 60 percent of our buildings are over 50 years old.

The CHAIRMAN. Ms. Brown.

Ms. BROWN. Thank you.

Mr. Chairman, I am going to yield most of my time to the Secretary. I want to thank the panelists that did the Assessment. I think there's an elephant in the room. There are people out there that would actually want to completely close the VA and privatize the entire VA system which is totally unacceptable and it is absolutely not what the veterans want.

And as you begin, I want you to discuss flexibility, and let people know how many people VA actually serves every day throughout this country.

Secretary McDONALD. Thank you, Ranking Member Brown.

As I was going through my confirmation process, I often got the question from senators, you know, from some senators, a small group, why don't we get rid of the VA and just give out vouchers?

So I studied that. As a businessperson, I wanted to know. And what I discovered was VA is not only essential for veterans, it is essential for American medicine and it is essential for the American people.

Three-legged stool. Research, we spend \$1.8 billion a year on research. We invented the nicotine patch. We were the ones who discovered that aspirin was important for heart disease, take an aspirin every day, first liver transplant, first implantable pacemaker. Last year, two VA doctors invented a shingles vaccine. I could go on.

That research is important for the American people. And I didn't even mention posttraumatic stress or traumatic brain injury or prosthetics, things that we are known for.

Second, training. We train 70 percent of the doctors in this country. Who is going to train those doctors without the VA? We are also the largest employer of nurses and the largest trainer of nurses.

Third leg is clinical work. Our veterans get the best clinical care because our doctors are doctors that not only do the clinical care but also do research and teach in the best medical schools of our country.

So I think the American people benefit from the VA and it would be a big mistake to even think about privatizing it.

Ms. BROWN. Would you expand on the flexibility as for VA's hiring and the flexibility with your budget?

Secretary McDONALD. Well, we talked about this in the last fiscal year. Flexibility for the budget is absolutely critical. We have over 70 line items where we can't move money from one line item to the other despite the fact that we have all agreed to give veterans choice. So the veterans have a choice, but we don't have the ability to move money where they decide to go to that choice.

So as you know, last year, we had asked your permission to use care in the community money to pay for care in the community because that care in the community money was in the Choice Act funds, not in the regular appropriation. So flexibility is absolutely critical because we have given veterans choice.

In terms of paying performance, we have put together some requests for legislative help. One example is the 80-hour week that we are required by federal law to use which is prohibiting our ability to hire doctors in emergency rooms. There is no private sector medical system that has this requirement.

As a result of that, we even had the VA outsourcing some of our emergency rooms and that is just wrong. So we need that legislation passed in order to free up our ability to hire the people we need.

Ms. BROWN. I have another minute and 19 seconds. Mr. Secretary would you like to add anything else?

Secretary McDONALD. Well, I passed along a letter to you and to the chairman on September 8th detailing the legislative request including the 2016 budget. Obviously operating under a continuing resolution is going to be terrible for us. It means no new programs. It means no way of meeting this increasing demand that we are seeing. Budget flexibility for the future, we talked about that.

Thank you for your work on the Denver hospital construction.

Provider agreement legislation, we have veterans' homes right now deciding not to renew their contracts with us because our provider agreement legislation is not clear. So that is a problem. We need to streamline and consolidate our care in the community which we are going to have a proposal to you before the 1st of November.

I need help in West Los Angeles. Senator Feinstein has put together a marvelous bill. The Senate held a hearing this week to allow us to get into extended use agreements with providers to build housing on that campus that we could use as bridge housing or supportive housing for homeless veterans. And we all want to end homelessness in Los Angeles.

There are several other pieces of legislation I have requested, but I think every member has this letter. And we would appreciate your hard work on this.

Ms. BROWN. Thank you.

Secretary McDONALD. And we will help.

Ms. BROWN. I yield back.

The CHAIRMAN. Thank you very much, Mr. Secretary.

I do look forward to working with you on the Los Angeles issue and I hope you will be looking at the enhanced use leases that are

on that property that probably shouldn't be on that property for whatever reason. And I know that there is a significant amount of turmoil going on out there right now. This should be about veterans. That is what the property was donated for and I think that is what this committee and that is what the VA should expect.

Secretary McDONALD. Absolutely right, Mr. Chairman. We have already sent out letters of notice of eviction to many of those users.

The CHAIRMAN. Many or all?

Secretary McDONALD. Many because, again, it depends what value veterans are getting from the presence of that provider, that partner on the property. We can go through that in greater detail if you like.

The CHAIRMAN. Okay. And the other thing, you talked about budget flexibility. I am waiting for language from you in regard to budget. You have talked about it for a long time, but we haven't received anything from you. We asked for it probably 30 days ago. We still haven't gotten anything from you and would like to, you know, if you really want budget flexibility, send us some language that you want us to work on.

Secretary McDONALD. Will do, Mr. Chairman.

The CHAIRMAN. Okay. Mr. Lamborn, you are recognized.

Mr. LAMBORN. Thank you, Mr. Chairman.

I want to thank all the people who put this assessment together. I want to thank the VA for cooperating and working so hard to help get the assessment done also.

And, Mr. Chairman, thank you for your work in bringing us to this point.

Secretary McDonald, I have a really specific question. I want to ask you a local question, then broaden to a general and national question.

But, first of all, I see in your written statement that you referenced a potential lack of funding for four major construction projects and six cemetery projects.

Since the cemetery project in my district is already well under design, is it still on track for construction funding in 2017 and will a funding shortfall in any way impact the Southern Colorado cemetery construction?

Secretary McDONALD. Thank you for the question, Congressman Lamborn.

Those six would be new cemeteries. The project in Colorado would be okay.

Mr. LAMBORN. Okay. All right. Then let me broaden to a larger, more general question, but very vital. I believe that access to care and streamlining community care are critical and we have talked a lot about that this morning already.

Are you on track to deliver the new Veterans Choice Program by November 1st, 2015 as promised?

Secretary McDONALD. I would say we are making progress. In fact, the authorizations climb by multiples every month. But I would say just like we talked about variability in the VA system, there will be variability.

I was with Dave McIntyre last night of TriWest, for example. It is going to take us a while to build capability in some of the geog-

raphies where not surprisingly there is a shortage of primary care physicians or mental health physicians.

But we are working it as hard as we possibly can, and I am hopeful and I believe that the consolidation of all the programs will make Choice even more effective. Why? Because we will go to one program that our employees have to administer and the veterans will only have one program for outside care. So I think it will simplify things dramatically.

Mr. LAMBORN. Okay. Thank you.

And, Dr. Giroir, I hope I pronounced that correctly. One of the things that you referenced of the many that need reform or improvement is physician productivity.

What are your specific recommendations in that very critical area? We could talk about so many things. I know we will during the rest of this hearing, but that is one I would like to drill down on.

Dr. GIROIR. Thank you for that question.

If you take the top line that, for example, VHA primary care physicians have 14 percent fewer patients or that the specialists are much below the 50th percentile in productivity, the immediate potential response might be, well, get the physicians to work harder, but it is a much more complicated problem.

As I outlined, there needs to be improved clinic space. That improved clinic space implies, though, that the VA has the authorities to make leases and less than six to nine years to do that. It means that hiring a nurse doesn't take six months or eight months or nine months. It takes two months like it does in the private sector because you lose those people.

It also requires scheduling. Imagine if your calendar was on six different separate screens depending on whether the person was a constituent, a non-constituent, a member. Well, that is sort of the scheduling system that we found in many of the VAs which makes it impossible to understand what the physician's real schedule is going to be.

So I think in the near term, these are the kinds of issues that can promote productivity even within the system and enhance the job satisfaction among not only the physicians and the staff but, again, as Mr. Byrne said, think of all those cornerstones, leadership, governance, operations and data and tools. And I think this is one example of them. And hopefully that answered your question to some degree, sir.

Mr. LAMBORN. Well, it really helps. And that is something I will work with you. I know all of us here, Dr. Roe and everyone here has a concern about that specific area, doctor from Ohio. And we all want to work with you on this. I mean, this is so critical. So I will work with Brad.

And thank you and I yield back the balance of my time.

The CHAIRMAN. Thank you.

Mr. Takano, you are recognized.

Mr. TAKANO. Thank you, Mr. Chairman.

Mr. Secretary, do you agree with something I have read in the report that the system's overhauls, the system's based overhauls described in the report could take at least five to ten years to take hold? Are we looking at that?

Secretary McDONALD. No. I mean, first of all, it is already underway.

Mr. TAKANO. Okay.

Secretary McDONALD. Second of all, you know, while Congress demanded this assessment and this assessment cost \$68 million from our budget, \$68 million, I had done my own assessment when I took over, my own root-cause analysis. I have done this before. And we are on track with many of the same things.

I appreciate the depth of the analysis. I can't do that myself, but these things are already underway and we are already seeing results. We wouldn't have had seven million more completed appointments if we didn't put in 1.8 million more square feet of space, if we didn't put in over 1,400 new providers, if we didn't put in over 3,000 new nurses. So progress is being made.

Mr. TAKANO. My concern is that if it were true, I have seen the turnover on this committee and the turnover within the Administration, we have one year left of this Administration, the change in Administration regardless of which party will occupy the White House, that part of the problem is the institutional memory.

And you mentioned you didn't agree with the idea of the commission, that you see this committee and the Senate committee as the—and I agree with you, but I think both parties need to be committed to constituting these committees with people that are going to stay here and to work with the department even as the top positions change.

Secretary McDONALD. The chairman and I have said publicly, and please correct me if I am misquoting you, that we have a unique moment in time right now where we have tremendous unanimity between the two parties, between the House and the Senate, and we have a new leadership team at the VA.

Thirteen of my top leaders are all new, 13. We have got the transformation underway. The work that was done by the independent assessment is incredibly helpful because of the depth of analysis. I think we just join arms and we do it and we create irreversible momentum in this transformation.

Mr. TAKANO. Mr. Secretary, I was disappointed to learn that the DoD let out the contract, a several billion dollar contract for health IT and that there is still no commitment for it to sync up with VISTA.

Secretary McDONALD. Their contract has a provision that it has to be interoperable with VA.

Mr. TAKANO. Oh, so there is a provision in the contract?

Secretary McDONALD. There is a provision for that and we are working very closely with them on that. We have so many joint DoD/VA facilities now. There is no turning back on this. We have got to have an interoperable—

Mr. TAKANO. Okay. Well, that is a relief to know. I mean, I have been fretting about the fact that that contract has been let out.

Secretary McDONALD. I would be happy to send a team of people to your office and have them show you the interoperability.

Mr. TAKANO. I would be very pleased to learn more about what you are doing.

The report also talks about, points out that many feel that in this area what was once VA's crown jewel has been allowed to stag-

nate and now 85 percent of VA's IT budget is now going to the maintenance of VISTA. You know, past efforts to update health IT, particularly achieving interoperability with DoD, have been mired with problems.

What lessons can we learn from past efforts to ensure that we are on a successful pathway to create a comprehensive system able to seamlessly operate with DoD——

Secretary McDONALD. To me, it all starts with——

Mr. TAKANO [continuing]. And the third-party providers that we want to do with——

Secretary McDONALD. Yes.

Mr. TAKANO [continuing]. Community care?

Secretary McDONALD. Well, that is absolutely critical. I mean, we have got to have interoperability with DoD, but the interoperability with the private sector is absolutely critical because we do agree that there will be times where veterans will go outside VA for care. So that interoperability becomes critical.

It starts with getting the right leader in place. We now have the right leader in place, LaVerne Council, who has been the head of IT at Johnson & Johnson, at Dell. She knows how to do this. She is very good. She is all over it.

Number two is we have got to take on the big systems. Our financial management system which ran into problems last year, last fiscal year was written in COBOL. COBOL is a language I wrote at West Point in 1971, 1972. You can't even find people writing COBOL.

Now, the chairman will bring up I am sure that we have tried twice before to replace that system and failed. I am telling you we can replace that system and we have the leadership to do it.

The scheduling system which was properly brought up, 1985, dates to 1985. We have put in 11 patches, but they are just patches. We need to overhaul the system. We need a new system as the doctor brought up. So we have a lot of systems work to do. We need the budget to do it and I will get you the right people to do it. And we will get it done.

Mr. TAKANO. Well, this is very heartening testimony, Mr. Secretary.

And, Mr. Chairman, I look forward to hearing what he has to say about simplifying our ability to do community care with private providers.

The CHAIRMAN. Thank you very much, Mr. Takano.

And I think that, you know, there are two words, interoperability, and that sounds great, and integration. And, you know, the integration of the system is the thing that is so critical. And I can understand maybe not integrating the private sector, but for DoD to continually be the agency that is pushing back over billions of dollars that have been spent, I mean, it is not helping.

Mr. TAKANO. I mean, it is unbelievable.

The CHAIRMAN. And even when Congress orders it to be done, it doesn't get done. And we want to help the VA and we understand that you are not the one that is causing the problem.

Secretary McDONALD. I am happy to put on a display, a demonstration for the committee so you all can see what we have achieved. In the end, it is all ones and zeroes and that is why the

interoperability is relatively easy to do. But we are happy to demonstrate it for you.

The CHAIRMAN. Thank you very much.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it.

I think Mr. Lamborn mentioned about the physicians and what have you. And one of you testified with regard to medical scribes. Why don't we have medical scribes available to all our VA physicians?

And I hear from my veterans and they say that the doctor really wants to treat them and, you know, they still have to scribe and it takes so much time away from the patient.

Dr. SHULKIN. Congressman, I think as you are suggesting, the issue of taking physician time away to spend on doing—

Mr. BILIRAKIS. That is my—

Dr. SHULKIN [continuing]. Entry into a medical record is a problem. It is a problem in VA. It is a problem throughout the healthcare industry. We are seeing practices, particularly in the private sector, of using scribes, something that I am very familiar with.

And we actually are beginning in different areas of the VA to begin to take a look at this as an option. I think it is a viable option that we are exploring. It is obviously an expensive option and given the size of VA, we are taking a hard look at that because using resources appropriately is certainly very important to us.

But it is an area that we are trying to lessen the time that physicians are spending entering information into records and more time with their patients. And the scribe system is certainly one of those avenues we are looking at.

Mr. BILIRAKIS. I appreciate—

Secretary McDONALD. As David says, we are testing, we are piloting the scribe. The flip side of the argument just so everybody understands both sides is if we simplify the medical record enough so that the alerts that come up really help the doctor and, you know, you want the doctor interfacing with that record to see those alerts rather than a scribe who may not be sufficiently medically trained to understand what those alerts do, so we have to work both sides of the equation.

Mr. BILIRAKIS. Thank you.

In your testimony, Mr. Secretary, you mentioned that this independent assessment reinforced the VA's own analysis. Has the VA done an independent assessment of their own?

Secretary McDONALD. We have. In fact, in my first few weeks in position, I traveled to as many facilities as possible. I have now been to over 220 facilities. And that has fed the information into our transformation plan.

I shared it with the chairman within my first couple of weeks. You might recall, it was a high-performance organization model. I shared it with the President of the United States. And that is what led to the 90-day plan called the Road to Veterans Day and also to the My VA transformation and the five strategies of My VA.

Mr. BILIRAKIS. Would you be willing to share it with us and—

Secretary McDONALD. Sure.

Mr. BILIRAKIS [continuing]. The public as well?

Secretary McDONALD. Absolutely. It is only two pages long. It is not 4,000 pages and it didn't cost \$68 million.

Mr. BILIRAKIS. Okay. Well, I would appreciate us taking a look at it. We really would. I think we would get a lot out of that.

Was there anything that VA's assessment discovered that was not included in the independent assessment?

Secretary McDONALD. I think what I would argue is my assessment was more about leadership and culture. It became very clear to me that I needed a new leadership team. Jim Collins who is a friend of mine likes to say you got to get the right people on the bus and get them in the right seats on the bus. The assessment talked a lot about leadership, but very specifically I need a new leadership team.

Secondly, I spent a lot more time about the culture. What do I need to change the culture? I called out two things, one called design thinking. Design thinking is a technique that is used to design delightful consumer experiences. And I can go into more detail of the training that we did two weeks ago or a week ago on that.

Secondly, Lean Six Sigma and train Lean Six Sigma. Think about design thinking as the way you design the experience for the consumer. Think about Lean Six Sigma as the way you improve productivity of what is backstage, what the consumer doesn't see.

Mr. BILIRAKIS. Thank you.

Last question. VA's presentation to the Commission on Care two weeks ago stated that VHA has begun to work on many of the 188 recommendations that were included in the assessment, the independent assessment.

Which of these assessment's many recommendations have you been working on and prioritized, if you can give me some specific examples?

Dr. SHULKIN. Congressman, be glad to do that. I think that in addition to what the secretary said, VHA has also had its own strategic plan called the blueprint for excellence. That was created after the Phoenix crisis and Dr. Jonathan Perlin came in for a period of time to help with VHA to create its own strategic plan.

So we have been hard at work in many of these areas that actually fit very nicely aligned with the recommendations that were identified in the independent assessment. They have to deal with these exact issues, how we prioritize our data, how we essentially address our leadership issues, how we engage our staff and improve morale and improve our hiring practices, how we ensure consistency and best practices across the system, something that both Mr. Byrne and Dr. Giroir identified today.

So these are all issues that VHA is hard at work at. I didn't say that we have done all 188 but that we have begun work on the vast majority of these. And we are going to use this independent assessment and what comes out of the Commission on Care to make sure that we are finding those appropriately.

Mr. BILIRAKIS. Thank you very much.

I yield back, Mr. Chairman.

The CHAIRMAN. Thank you very much.

The secretary keeps reminding us that we have invested \$63 million or thereabouts for the—

Secretary McDONALD. Sixty-eight million.

The CHAIRMAN. Okay. I would like to remind the members that we just raised the cap on the Denver hospital to \$1.675 billion.

Secretary McDONALD. Sir, it is not a hospital. It is a complex of about 16 buildings.

The CHAIRMAN. It is a massive cost overrun and screw-up.

Secretary McDONALD. And we agree with that.

The CHAIRMAN. Thank you.

Ms. Titus.

Ms. TITUS. Thank you, Mr. Chairman.

Maybe we should have used the \$68 million to apply to that hospital.

The CHAIRMAN. They are probably going to need it before it is over with.

Ms. TITUS. That is what worries me.

Thank you, Mr. Secretary, for being here. It is always a pleasure to see you.

I just want to begin by taking exception to the doctor's blanket statement that veterans are voting with their feet by going to the private sector. I think that is a spurious conclusion. I think some of those veterans are going to the private sector not because they want to but because they have to because they can't get the services, can't get the appointment, don't live close enough to a facility, but they prefer the VA.

And that kind of brings me to my general point. I made this on the floor last week that I am worried about how the VA and how Congress are funding the needed healthcare for our veterans.

Last week, as you heard many times, we voted to fund the construction of the Denver facility. Now, I know it is a good facility. I am not questioning the importance of it. All veterans everywhere need care. But when we are talking about paying for it, we are just moving around the deck chairs. We are not saving the ship, I am afraid.

We are waiting for the specific recommendations of how the VA is going to move that money around, but what I have seen so far is pretty troubling. We are robbing Peter to pay Paul. And two of the points have come up this morning.

You mentioned the COBOL antiquated language of computers and IT problems, but one of the recommendations for paying for Denver is taking about \$50 million out of the IT budget. You also mentioned that you are going to propose cutting funding for retention and recruitment programs and, yet, one of the recommendations and one of the problems that is seen is that we cannot hire enough doctors, even enough much less the best and brightest and that our hiring process is much longer than you find in the private sector.

I talked to the head of the medical facility in Las Vegas and he said they had run out of this money. They need more money, not less, as an incentive to get the professionals there.

Now, I am not just blaming the VA. I think Congress is at fault, too. You mentioned that these short-term CRs are not helpful. Certainly I think they are irresponsible. And also we have these arbitrary caps that don't make any sense. They don't allow us to accommodate future needs. You know, maybe we should just put the

VA in the OCO account. That seems to be where everybody wants to put the money.

But I would like to ask you how important is it to get a real appropriations bill? I mean, and also do you think you will be coming back to us with another crisis situation? We are going to have to close down hospitals if we can't move this money around or we can't get some more money. Give us kind of a projection for that.

Secretary McDONALD. Well, I hate to predict a crisis, but remember the rate at which we are—with these new hepatitis C drugs which are curing hepatitis C for the first time without the side effects that occurred previously. Remember veterans have a higher incidence of hepatitis C than non-veterans. We are trained to cure all of those veterans with hepatitis C. That is what helped create the budget crisis of the last fiscal year.

That demand for the hepatitis C drug is not going to abate because suddenly it is October 1st. So the continuing resolution is obviously not sufficient to be able to continue on the path we were on in order to treat the hepatitis C. That is just one example.

The other example, of course, is as you said, I said earlier, on average, veterans are using the VA for 34 percent of their care. Seventy-eight percent of veterans have a choice, TRICARE, private health insurance, Medicare, VA. They choose VA because of the care. That is what the VFW study said. Eighty-two percent choose VA. Eighty-seven percent recommend VA.

If that 34 percent number continues to rise, which it appears to be doing as more people are coming into the system as the care improves, then we have a real budget problem. And the budgeting the way we do it isn't going to work. It is not the way a business would do it.

I mean, we started the budget for 2016 two years ago. The drug was invented, you know, between the time we started the budget and the time the budget is actuated. So that becomes a problem. We need a more dynamic system. We also need to do a better job forecasting. And that is on us.

And then the inflexibility causes us to end the year with pockets of underspending where if we could aggregate all of those funds together, we could make sure that they were all spent on behalf of veterans.

But because this particular fund isn't maybe needed and we don't want to go over, we are always underspending. In business, you tend to aggregate funds so that you spend all the money that you have appropriated.

Ms. TITUS. And I worry about the personnel for the appeals system. You talked about the need for personnel for the original backlog, but you have got over 300,000 appeals in the system right now and that number is going to grow, too.

Secretary McDONALD. It is. We are working right now to re-engineer that process. We will need some new legislation. We have been working with the veteran service organizations on something called the fully-developed appeal that will accelerate the process, but we need more people. And those people were in the budget proposal.

Ms. TITUS. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Roe, you are recognized.

Dr. ROE. Thank you, Mr. Chairman.

And also thank the committee for all the work you all have done.

I am going to pass along a little wisdom I got from an old GP when I started my practice many decades ago. He said, son, he said you need to follow the three As in the practice of medicine. One is availability which the VA has flunked. Two is affability. Do they like you once they get in? Third is your ability.

And I think one of the things we ought to talk about and I am going to bring up some issues that came up with my veterans' person at home and walk you all through down at the ground level, not at the 30,000 foot level where we have been.

On productivity, I had a colonoscopy a couple of weeks ago. The two docs I went to see in the private sector, a nine iron from over at the VA, do 30 to 40 per day. You would overwhelm a VA anywhere if they thought they had to do 30. And this was just a routine day for these guys in private practice.

And you talk about scribes. My goodness. Hiring a six figure doctor to make them 15 or 20 percent more productive with a \$12 or \$13 an hour employee makes perfectly good sense. Almost every private doctor you see now are shifting to that. It is an added cost to them, but it allows the most skilled person in the healthcare system to stay productive and let that data entry go to somebody who is of a lower skill.

And I think you are going to have to switch to that to make up the difference. There is just not enough doctors in America with the current system. It slowed me down by about 25 or 30 percent, the electronic health record did. I tried to speed up. I used everything I could. I just couldn't do it.

And on facilities, I think you need to be innovative. We had a facility in our area where a local hospital had been vacated and they leased that to the VA for a dollar a year. We need to be looking at innovative ways like that.

And one of the things it said in the report, and by the way, this was a fantastic job that was done, was that the capital requirements over the next decade, the funding levels are two to three times more than the funding levels are and then it goes down two bullet points later and says VA construction costs are similar to other public agencies but double the private industry best practices. And VA's time to complete exceeds both the public and other private sector. So you may have enough money if you can just get it done on time and use those other things. So I would point that out.

Let me go right to what I wanted to talk about which is my own veterans' officer at home, the person that does my work at home. And basically what she is saying is how do you get an appointment through the Veterans Choice Program? She said she had been trying to put together a summary. And what is happening is there are two ways you get in there. A veteran can either be eligible by a 30-day wait list or more than 40 miles. And most of the problems she saw were the 30-day list.

And this is what happens. Below is the information has been given to me by the rollout of the program. And in my experience, there appears to be a breakdown somewhere in this process, but I

have been unable to get clear answers on how to fix it. The VA blames TriWest. TriWest blames the VA.

Eligibility is determined by the VA primary care doctor if the appointment is past 30 days. The non-VA care staff then uploads this list of eligible veterans to the VA central office here in Washington nightly and the veteran is told to wait five to seven days and then call TriWest. The central office then sends the information to TriWest. It can take three to seven days. If the consults don't get added, medical documentation didn't get uploaded, authorization gets canceled, then the veterans are on a merry-go-round.

Look, when they came to my office to get an appointment, I said you need an appointment with Dr. Smith. They went out front and made the appointment. That is what should happen. It ain't that complicated.

And all this in between and I can go on. TriWest has a different view of it. I want to submit this to the record because it really gets to the bottom of what is actually going—

The CHAIRMAN. Without objection.

Dr. ROE. Thank you, Mr. Chairman.

The non-VA care staff were given no training on this and they basically were left just to wing it on how to make these appointments. That was one of the things that was brought up in the report how local non-VA care staff increased from five to 15, but still are struggling to make all these appointments.

And listen to this right here. There is talk of calling each patient for every appointment to make sure they keep it. If the patient says I don't want to go, they still are told to call them two times a month past the appointment time. That is a complete waste of time.

And the outpatient clinics also ought to be able to add patients to the electronic wait list instead of sending them over because an appointment may come up. Veterans get left out like that.

And the TriWest portal is not very friendly. Private doctors who do not like jumping through all the hoops of the Choice Program are saying they must give a percent of their fee to TriWest in order for TriWest to file the claim.

So we have a clinic that is closing in our office, in our VA, our chiropractic and pulmonary clinic because the doctors are just fed up with the way the system is. It is so bureaucratic.

So, anyway, I could go on and on. This is very extensive. This is on-the-ground stuff that is going on today at our medical center. And I bet you it is going on around the country. And I think these are things I will submit to you so you can get to work on this. And, again, appreciate the effort that you put into it.

Mr. Chairman, there is some valuable information here for the VA to use. And I yield back.

The CHAIRMAN. Thank you. Ms. Brown, you had a question?

Ms. BROWN. Yes, I do. I am meeting with TriWest today. You cannot send a veteran to a medical agency or anywhere else until they get prior approval from VA. It is important that all doctors review reimbursements. No person in my office can send someone to a doctor. The request must go through the system so that a veteran can receive prior approval. How long and why does it take so long for that physician to get reimbursed?

Secretary McDONALD. We have flow charted that process, and let me let David talk about the improvements that we have made to that process. He will answer questions one and three, and I will take two on the facilities.

Dr. SHULKIN. Okay. Dr. Roe, I think your old adage on the three As is exactly right. And you have to remember, we brought this choice system up in 90 days. This is a national, very complex system. And what we have heard after bringing it up in 90 days is exactly the type of feedback that you have been hearing from your constituents. The Secretary and I are both out in the field. We understand that these problems are happening. And so what we have begun to do is to redesign the system and to process map it out.

Both the Secretary and I spoke to the CEO of TriWest last evening and we are beginning now to make outbound calls to the veterans. Before they had to call in. We are beginning to actually embed Tri-West staff in the VA so that they are working in teams. And we are beginning to start eliminating some of those steps.

It is going to take a while. It is painful to watch this when you hear stories like what you are hearing. But we understand the problems there. We are working very hard. We think TriWest and Health Net are working to help us make this system better and we are committed to doing this with urgency.

Secretary McDONALD. Relative to facilities, we agree with your comment. In fact, one of the things we have talked with Rich about is figuring out how we can come up with a total system map that includes all the DoD facilities, all the VA facilities, Indian Health Service, medical school affiliates, so we can better understand where do we need to invest? Where are the gaps where we need to invest, where facilities do not exist?

With the draw down in the Wars in the Middle East what we are finding is DoD has a lot of capacity that we can use. Martin Army Hospital is an example I used earlier, but there are many examples of where we are working together with DoD so that we can use the same facilities.

If you look at the space that we have been doing over the past year or so we have been leasing more space than we have been building, almost to a factor of two to one. So I mean that is going to continue to be the case because we have got to be more flexible to meet the demand where the demand goes.

The CHAIRMAN. Thank you. Mr. O'Rourke.

Mr. O'ROURKE. Thank you, Mr. Chairman, and to the ranking member for organizing today's hearing, and to the panelists for joining us.

I want to get back to a question that was raised earlier about the role of the VA system going forward and a question raised by MITRE and Dr. Giroir, the letter that you signed to the Secretary on September 1 suggesting that it is worth looking into whether or not the VA should focus on specific areas of service related conditions. And in some of the things that we have heard from the Secretary about the 34 percent utilization rate today, and that for each additional percent of utilization it costs the VA I think \$1.4 billion was the number that we got from you. And that 34 percent is just of those veterans who are currently eligible, I mean enrolled. It

does not include all eligible, which I believe is 9 million, or all veterans in the country, over 20 million.

So from a fiscal perspective it is hard to make the case that the VA should provide all care to all veterans all the time. I just do not know how we could do it fiscally. I think there are some very serious operational concerns that are self-evident to everyone here. And then on the moral dimension we really have a crisis in mental healthcare. When officially we know that 22 veterans a day are taking their own lives, and most veterans organizations that I have spoke to think the real number is certainly much higher than that. And when we know that care delayed becomes care denied, turns into tragic outcomes for veterans and their families, I want to ask you and Mr. Byrne and the secretaries about this question of prioritization.

Should we be prioritizing in the 41,000 funded but unhired positions within VHA mental health providers? Should the VA become a center of excellence, as I think is suggested in the MITRE report, or one of the issues that we should look at, so that perhaps 100 percent of eligible veterans who have Post Traumatic Stress Disorder, are suffering from the consequences of Traumatic Brain Injury, have Military Sexual Trauma, have traumatic amputations or other significant combat and service related conditions, they go to the VA because it is a center of excellence. There are no access issues and we prioritize hiring and resources there. And when we refer people out into the community we refer them out for conditions that are comparable to what the general population has, whether that is diabetes or the flu, or someone looking at audiology, or your feet, or any number of other conditions that are comparable. Tell me, I will start with you, Dr. Giroir, what is wrong with that conclusion and why the commission has not reached that already?

Dr. GIROIR. Thank you for the question. And there were so many statements that we do support very strongly, what you said. Among the first, the first point, I think it goes back to aligning resources with demand. And the VA in some aspects is in an impossible situation because the demand could literally double overnight depending on how the services are provided and the demand for the veterans. And that is an impossible situation to plan for X, 2X, or 3X. And you know the numbers as we outlined them. So to specifically define what the VA is going to do, to fund it specifically for that, and to provide other sources of care for the remaining is the main point. We have to align demand with resources, however that is defined. And it could be done two or three different ways. They can all work but you—

Mr. O'ROURKE. Is some demand more important than other demands? So if a veteran is coming back from Afghanistan with Post Traumatic Stress Disorder and cannot get in to see a mental healthcare provider, is that not more important?

Dr. GIROIR. So I am not going to say more important. But what I will say, which is the essence of your question, sir, is the panel, the blue ribbon panel does feel, and I think it is true, that there is care for these kinds of specific issues, Post Traumatic Stress Disorder, Traumatic Brain Injury, traumatic amputation, severe burns and injuries, that nobody on the planet does it as good as the VA.

Mr. O'ROURKE. Right.

Dr. GIROIR. And it needs to be comprehensive care, not just in the operating room, but all the social services, the mental services, the comprehensive provider care that needs to be done. And certainly at the essence that is something the VA, among all things, needs to be preserved for. Whether the VA should take care of every patient with hypertension, or diabetes, or other issues is a question that needs to be resolved by the governance. But clearly those core issues are something that our veterans rely on, will rely on. And the future injuries of war that we cannot predict, the VA must always be there for that in our opinion.

Mr. O'ROURKE. I am out of time so I will have to follow up with the other panelists at a future date. But I would certainly love to sit down and talk with each of you and get your responses to that question.

Secretary McDONALD. We would look forward to that opportunity. We have eight classifications today that help sort through some of that and we would love to sit down and go through it with you.

Mr. O'ROURKE. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Abraham, you are now recognized for five minutes.

Dr. ABRAHAM. Secretary McDonald, we will start with you, sir. You have said on multiple occasions that you want the VA to be run as a business. You being of a business background with Tide and Proctor and Gamble know that certainly the VA could be a more efficient entity if it were run in a business model.

I want to reference, you said that you were somewhat opposed to the governance board having some oversight of the VA. Why would you be opposed to that, sir?

Secretary McDONALD. I am not opposed to a board as such. In fact, I even set up an external advisory board which is loaded, just like the blue ribbon panel, with experts to help advise me. The reason I did that was I was disappointed that I have attended lots of committee hearings but nobody wanted to talk about the transformation of VA. We were talking about problems that occurred in the past. So I do see the role of the board. But my thought is that if you as Congress really decide you need this board, is that not an abrogation of your responsibilities? Cannot we, I think with the chairmen that we have, with the committees that we have, with the unanimity of purpose that we have, we can do this ourselves without needing a separate board.

Dr. ABRAHAM. And we want you to do it yourselves.

Secretary McDONALD. Well no, I mean I need your help.

Dr. ABRAHAM. We want the proof in the pudding. Well, but we understand. But again, we do not want to abrogate our authority or our responsibility.

Secretary McDONALD. Absolutely.

Dr. ABRAHAM. But we want you to do what you are paid to do, and herd your people into the right direction and make this VA system a better system. Like Dr. Roe, we are back in the districts on almost a weekly basis, either on the weekends or during the week. And we are, you know, our veterans really are not feeling the love, so to speak. I mean, we are still having some massive

issues. And you go across anywhere in these United States and these same issues come up and up.

Dr. Shulkin, I will also reference Dr. Roe on these scribes. I have used scribes for years. And I understand the alert deal. But let me tell you, they work. And they work very well. And you as a physician can increase productivity at least by 30 to 40 percent if you have a scribe that is knowledgeable just in the system. His other point with the three As, his first one was availability. Another novel idea, and I am sure you guys have thought about it. If you expand hours of your VA clinics, I assure you, as being a director of a multi-doctor practice, there will be nurses and doctors that stand in line that will take that 5:00 p.m. to 11:00 p.m. shift if they have children, if they have a spouse that works. And again, you are using just the same facility and just getting more efficiency out of that. So again, you know, these are ideas that—go ahead, sir.

Secretary McDONALD. Well I will just say that our RVU productivity is up eight percent, over eight percent—

Dr. ABRAHAM. Okay.

Secretary McDONALD [continuing]. On a budget increase of about 2.8 percent.

Dr. ABRAHAM. All right, now let me interrupt you—

Secretary McDONALD. And extended hours is one of the reasons.

Dr. ABRAHAM. And I know Dr. Wenstrup on my right here, he has referenced this RVU situation before. Now are we to the point now where you can give us an RVU number?

Secretary McDONALD. Yes.

Dr. ABRAHAM. Okay. Excellent.

Secretary McDONALD. And David can talk in more detail about RVUs.

Dr. ABRAHAM. Please.

Dr. SHULKIN. Yes, I mean I think all of your points are excellent, Congressman. We are, we are actually doing many of the things that you have talked about. As the Secretary mentioned, we have extended hours, we have improved productivity on the RVU basis approximately eight percent, but many of our specialties well above that as well. And we are looking at issues like the scribe. But what we want to do is to take the independent assessments recommendation and look at these as system issues rather than pushing on one particular—

Dr. ABRAHAM. And I understand that. And, you know, Mr. Byrne gave the four cornerstones of what his assessment said. And if you look at them, I mean, that is just basic Business 101. I mean, it does not take a rocket scientist to figure this stuff out. What we are asking you guys to do is take it to heart and actually do it.

While we have got just a few seconds left, Secretary, do you now have the power, have we as Congress empowered you now to, you talk about changing culture, well the one way to change culture is to fire some people that are not doing their job. Do you have that power now to do that?

Secretary McDONALD. Yes, we have terminated over 2,100 people since I became Secretary.

Dr. ABRAHAM. That is actually firing? That is just not retiring? That is—

Secretary McDONALD. Well, it is terminations. It is terminations. It includes some people who were on a probationary status where we did not hire them afterwards. But I think, you know, if you want to look for points of accountability, let us talk about a gentleman named Cathedral Henderson in Augusta, Georgia, who, you know, is now, has 50 counts of falsifying consult records, each one carrying a potential fine of \$250,000 and in total potentially look at five years in jail. He is going to trial. So I am, you know, while I would like to do it faster we are holding people accountability. We are using all the forces at our ability, whether it is the Office of Special Counsel, IG, or in this case the FBI.

Dr. ABRAHAM. Okay. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Walz, you are recognized.

Mr. WALZ. Thank you, Mr. Chairman, and ranking member for holding this. Thank each of you for your citizenship, for being involved in this. This is not going to be fixed by Congress, it is not going to be fixed just by the administration, it is going to be fixed by citizens demanding and using our best and brightest to figure out a way to do this. So I for one am grateful.

And Mr. Secretary, thank you. And I am glad to hear you say, while not totally accurate, some of us have been asking to have this conversation on long term systemic change. I brought up many times the idea we had a quadrennial defense review that drove policy, strategy, and budgeting from that. We never had such a thing on the VA. And so I think it is really heartening. I appreciate all the work that went into this. I think hearing from Dr. Roe, it sounds like he did just what we talked about, Mr. Secretary. We kind of did a post-mortem on someone's experience and those folks out there. So I hear TriWest a lot. Keep Health Net in mind, too, on this.

Secretary McDONALD. We do.

Mr. WALZ. I know you do. And I am grateful for that. I wanted to come back where Dr. Abraham was, because I thought this was an interesting point, Mr. Secretary. Of all the recommendations, and in full disclosure I always say this because it certainly influences my decision, I represent the Mayo Clinic area. So I look at how Mayo Clinic's model is on outcomes. And this idea of the recommendation of a non-governmental entity, I looked at that and tried to understand it. But I kind of think that I agree with where Dr. Abraham was talking about you have a job to do, we hired you to do it. The public hired us to do a job, too. I am a little bit uncomfortable, too, putting someone between us and them. I am just not sure we have the resources or if we have done it well enough. So I would kind of like to get each of your, because I know this board concept, it is with Mayo, it is with Kaiser, and all of that, and I know that is where it came from.

Secretary McDONALD. I have over 25 special advisory committees today, 25. I like the statement Jack Welch used when he talked about GE, we are trying to reduce levels and layers. We are working very hard at that. That is why we have not filled a lot of positions. That is why we are reducing the number of VISNs from 21 to 18. That is why each state now will generally have one VISN. Jack Welch used to say that adding levels, layers, and boards is

like putting on more sweaters. You do not know it is cold out because you have got all these layers on.

I like to have my pulse on what is going on in the business. That is why I travel so much. I do not think that creating a separate board is going to stop this committee from doing what this committee does. And I would just like to transform what we do and to be working on the transformation in the future rather than what we have been doing, which is focusing—

Mr. WALZ. Do you think it is possible for us to assume that role, too?

Secretary McDONALD. Yes, sir, I do.

Mr. WALZ. Because I would like to be that. I would like to be part of this transformation project, not just coming in here and screaming when there is a fire to put out. Secretary McDONALD. Yes, I do. And you are right, you did bring this up in the past. So, you know, we are all for it.

Mr. BYRNE. So the recommendation that came from our assessment actually originated from best practices in the private sector, as you mentioned with Mayo.

Mr. WALZ. Right.

Mr. BYRNE. I think the transformation requires a strong partnership and level of trust with the board, whoever they may be. And in a situation as complex as the Veterans healthcare system, which is very complex and very distributed, it is not something you can pick up in just a couple of hours. You saw when we did an in depth study the amount of effort it took. For people to have enough familiarity to help make strategic decisions and guide levels of expected performance, you have to spend time. There is just no way around that.

I think it would be great if this body did that. But some organizations say, if I can endorse a proxy to help advise them and spend the time to become familiar, and to build those levels of trust, then—they can use that as a faster way to make decisions and improve performance. To be honest there are 25 advisory boards, but none of them really have governance properties. And that is why we thought a governance board would actually help build a better partnership. But if it does not build the partnership, then we would not recommend it—is the purpose of the governance board is to build trust by—1682 by having people spend more time, and also to give you access to the best experts in the private sector. Because this is not just about putting time in. This is about putting time in with people who have done this job from all different stakeholders perspectives.

Mr. WALZ. Well I would like to spend more time on that, I think. Because I think we as a body need to explore this, or whatever, because I am always fearful of giving away our power. Because I thought that maybe, and we talked about on, I think I have a record streak going here saying Denver so I am going to say it today again, Denver, that I said maybe we should be involved in change orders if that is what it takes to get our hands in this and take responsibility. So I will leave you with this.

And Mr. Secretary, I know of all the things you have got on your plate, you have got a lot. But I think people here need to recognize last week this Congress allowed the Agent Orange Act to expire.

And I think it is altogether possible that the study that we asked for an extension so we could see it that is going to come out in March is going to add hypertension and stroke to that. And you are going to add literally hundreds of thousands of people who by the scientific data are going to show, experience these catastrophic health consequences because of their exposure to Agent Orange and the pressure is going to be on. If we do not have the courage to do it they are going to ask you. And much like the Nehmer claims it is going to add to your work. And I just lay that out there for our folks to start thinking ahead.

Secretary McDONALD. It is a very good point. And we have been working very, very hard to clean up some of the things that have been hanging around. C-123, Agent Orange, for example, we have now cleared that up.

Mr. WALZ. Which I very much appreciate.

Secretary McDONALD. No, you know, this is the right thing to do. Brown Water Navy, Blue Water Navy, we are going through all of these things detail by detail. The point is that, you know, I get lots of letters from members of Congress wanting to add more and more benefits for veterans, and I support that. But we also need the funding and the personnel to be able to do it.

Mr. WALZ. That is right. That is right.

Secretary McDONALD. If we added, for example, and this is not in the decision. But if we added another pre-condition, and we do not get the people to do it, the 80-plus percent progress we have made on the backlog of claims will go away.

Mr. WALZ. That is correct.

Secretary McDONALD. Because—

Mr. WALZ. So your decision is going to be either to deal with that or deny the claims. And I think all of us here to recognize we are part of this.

Secretary McDONALD. Well, we would prefer to do what is right for the veteran—

Mr. WALZ. That is correct.

Secretary McDONALD [continuing]. And then have you help us get the people we need to get it done.

Mr. WALZ. I appreciate it. Thank you for the time, Chairman.

The CHAIRMAN. Well, and I think part of the problem is, and we are looking backwards. But we were never asked for additional resources in order to deal with the presumptive claims that were added in the past. And so, I mean, we are more than willing to help. We were not asked. And then all of a sudden there was a backlog, and folks were using that as an excuse for the backlog. And we just, we need to work our way through it. So I agree with Mr. Walz, and with the Secretary as well. Mr. Huelskamp?

Dr. HUELSKAMP. Thank you, Mr. Chairman. This is an excellent topic for us to discuss. It is something obviously we wanted to happen last summer, and a chance to actually get down into it. So Mr. Byrne, I appreciate that. I am struck, though, by some of the words that are used in here. And Mr. Secretary, I appreciate you being here. But looking at this independent assessment, and I know it is a lot of pages, Mr. Secretary, if I missed that. How much have you read of this assessment?

Secretary McDONALD. I have read all 4,000-plus pages. How much have you read?

Dr. HUELSKAMP. Excuse me?

Secretary McDONALD. How much have you read, sir? I have read 4,000 pages.

Dr. HUELSKAMP. Well, good. That is your job.

Secretary McDONALD. That is my job.

Dr. HUELSKAMP. And your job is to take a culture of non-accountability on. There is a culture of silence. Do you disagree with that assessment? That folks are reluctant to speak up because of your lack of leadership?

Secretary McDONALD. Last September there were people who were unwilling to speak up. That is the reason I have been to over 200 facilities, done town hall meetings in all of them. And I was——

Dr. HUELSKAMP. Does it still occur? That is the question. Could you answer the question please?

Secretary McDONALD. What was the question again?

Dr. HUELSKAMP. Is there a culture, do you disagree with the assessment that there is a culture of silence that your employees are afraid to speak up?

Secretary McDONALD. I disagree with that. In the town hall meetings I have——

Dr. HUELSKAMP. Do you disagree with the fact that you are still in the midst of a leadership crisis at the VA?

Secretary McDONALD [continuing]. Employees are willing to speak up.

Dr. HUELSKAMP. Assessment, you are in the midst of a leadership crisis.

Secretary McDONALD. I am in the midst of a leadership crisis. That is the reason I brought on 13 of 18 new leaders, and that is also why I am asking you to step up and provide the support we need for the demand that we are facing.

Dr. HUELSKAMP. Do you need more staff in your headquarters program office? Is a 160 percent increase in five years, is that not enough to take——

Secretary McDONALD. I just want to, I saw that in the study as well. And I refer back to a letter I wrote the Chairman on September 14th of 2014 that talked about the fact that the way VA—— actually, I am sorry, it is September 16th of 2014, that talks about the way VA codes these positions. Many of those people who show up in the headquarters staff are not in the headquarters staff. They do not live in Washington, DC. They are outside Washington, DC. The letter is right here. We can look at it.

Dr. HUELSKAMP. So there was not a 160 percent increase in your staff in the——

Secretary McDONALD. No.

Dr. HUELSKAMP. How much of an increase did you have?

Secretary McDONALD. The VA work force grew 36 percent between the end of fiscal year 2007 and through August of 2014. The largest growth was in positions that interact daily with our veteran population. Medically focused positions, such as nurses, physicians, medical assistants, and claims——

Dr. HUELSKAMP. How much of an increase in the central office is my question.

Secretary McDONALD. About——

Dr. SHULKIN. I can just help a little bit about that. The largest increases, Congressman, were essentially where field positions were aggregated and then moved into the central office. That was 420 positions between workforce management, between logistics and procurement, and emergency preparedness. So while there was an increase between 2009 and 2014, it was not nearly as large as 160 percent because it was an aggregation of field positions to the central office.

Dr. HUELSKAMP. The assessment also compares the VHA to other nationwide or regional providers. And the comparison that caught my interest, Mr. Secretary, was of a provider that cares for almost 3.3 million more patients but does it with 114,000 less employees and 1,800 less physicians. Can you explain why you need 114,000 more employees to take care of 3.3 million fewer patients?

Secretary McDONALD. As you know, our patients typically have very complex situations. Many of them have been created by the battlefields that they serve on. So it is very difficult. And I think most of the studies that have been done, including the Congressional Budget Office study, find it very difficult to compare what goes on in the private sector and what goes on in VA. And maybe Dr. Shulkin would like to add, because he has been in both.

Dr. SHULKIN. Well, you know, first of all part of our job is to figure out how we can always do things better and more efficient. So I do not want to say that we are not always looking at that. But coming from the private sector, we are doing things in VA that are not done in the private sector. We are addressing many, many more behavioral health, psychological issues. We are addressing caregivers. We are addressing homelessness. We are addressing services in our VETS centers that just do not exist out in the private sector. So the comparisons are hard to make——

Dr. HUELSKAMP. Let me ask Mr. Byrne, who actually wrote the assessment, does that comparison make sense? Or——

Mr. BYRNE. So the comparison I believe you are talking to is probably with Kaiser. I have to go back and look at the data. But there are several different aspects to make the comparison. One of them is that there is an adjusted risk for the different patient populations, and the veterans are different, sicker, and older than other populations. That is one factor. We did not do that risk adjustment. Secondly, to be quite honest, the number of missions in the VHA are much more complex than in the private sector. We mentioned R&D——; that is a massive, \$1 billion to \$2 billion of research a year they do. You are also talking about the training of 120,000 people annually.

In the example of Kaiser, they are laser focused on just healthcare. And that makes their ability to have efficiencies and focus much, much easier. Now if they took on those other things, I do not know if they would be more efficient or not, but that is why it is very hard. And remember also, Kaiser is one of the high-performing healthcare systems. The reason we went to those is because when we——

Dr. HUELSKAMP. So, and I am out of time. Why did you use that comparison if you have no basis to make the comparison?

Mr. BYRNE. The——

Dr. HUELSKAMP. I did not read the 4,000 pages, and——

Mr. BYRNE. The reason——

Dr. HUELSKAMP [continuing]. Could you explain that?

Mr. BYRNE [continuing]. When we compared VHA with the private sector, they are about average. But we saw a large variation that was unacceptable. So we said the only way to make that variation go away is to get the best performing practices. And that is why we shifted midway and said let us start looking at the highest-performing healthcare organizations and make that the bar for VHA. Because that is the only way we felt you could eliminate the variations. If VHA is already about average, those variations are going to be maintained if average benchmarks are their bar.

Dr. HUELSKAMP. So in summary you cannot compare them? Is that your assessment?

Mr. BYRNE. I cannot do a comparison.

Dr. HUELSKAMP. Okay. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman. I want to thank you, Mr. Secretary, and I applaud your efforts for taking sort of a systemic look at this, maybe a 50,000-foot view. Because I started with this committee in 2007. We have seen the budget increase greatly at that time. And we have seen some improvement. For example, the disability claims have improved. There still needs improvement. But then all of a sudden this crisis in healthcare pops up. It seems like it is a whack-a-mole. You hit one thing really hard and some other problem pops up. So a systemic look at this is really needed and I appreciate that. Do you agree that a systems approach is the right approach moving forward?

Secretary McDONALD. Yes sir, I do. I think one of the best business books ever written was *The Fifth Discipline* by Peter Senge. He devotes a lot of time in that book to systems thinking. I am an engineer. I am a systems thinker. And I would, I like the systems approach that the independent assessment took. The only thing I would have liked more is if that independent assessment included in the system Congress.

Mr. MCNERNEY. Is there any way to get them to add that assessment?

Secretary McDONALD. Well, I have made some suggestions. Their proposal was an independent board. I think, what I believe is that this is a unique moment in time. We have got two great committees with two great chairmen. We have got unanimity in the country. Let us work together. I think we can get it done without the board. And by the time, we will get it done before the board gets set up.

Mr. MCNERNEY. Well one of the problems in that interaction between Congress and the VA is, in my opinion anyway, we have hearings and it is not clear that we are being told the whole story. I mean, we can ask a specific question and we will get a specific answer, but they will avoid the greater problem that may be something that we can help with. So we need a better level of communication between our two bodies.

Secretary McDONALD. We, sir, we want you to know all the problems. And believe me, even though we have made some progress it is just some. We have a lot more to do.

Mr. MCNERNEY. Granted. The independent assessment looked at the demographics of veteran populations and stated that only half of the veteran population uses the VA healthcare. What tools do you have available to help capture more of the veterans that could use healthcare?

Secretary McDONALD. We had developed an advertising campaign with the Ad Council. I do not know how familiar you are with the Ad Council?

Mr. MCNERNEY. Right.

Secretary McDONALD. But the Ad Council does pro bono work, where companies put money in. We had done an independent campaign to encourage more veterans to sign up. We have not aired that campaign completely yet because we need to build the capability to make sure we can take in those more—

Mr. MCNERNEY. So have you had an independent assessment of the return on investment that you have made in that?

Secretary McDONALD. We have not yet. You know, we have done testing, the Ad Council did testing at their cost to show that the ads were effective but we have not done any piloting of it to see how many people would come into the system. As I said earlier, and Dr. Giroir supported this, veterans are only using the system for about 34 percent of their care. And every percentage point is \$1.4 billion. So we have to be careful as we bring more people into the system that we can take care of them.

Mr. MCNERNEY. All right. Thank you, Mr. Chairman. I am going to yield back.

The CHAIRMAN. Thank you. Mr. Secretary, is it your job to make sure that veterans receive healthcare? Or that veterans, more veterans come into the VA system?

Secretary McDONALD. Well I think it is to take care of veterans. I mean, that is what I am here to do.

The CHAIRMAN. So if they are getting their healthcare somewhere else, they are getting—

Secretary McDONALD. Well if a veteran wants to get his healthcare somewhere else, that is fine with us. We are here for them. And as the VFW showed, you know, 82 percent choose the VA, 87 percent recommend the VA. So you know, we are here for them and we want to build the capability for the number that come.

The CHAIRMAN. And so my question is, is the ad focused on getting people to come back into the system? Or is it to get people who are not getting healthcare at all—

Secretary McDONALD. I am sorry. No, it is to teach them how to sign up on eBenefits.

The CHAIRMAN. Okay. So they are not even—

Secretary McDONALD. They are not even in the system.

The CHAIRMAN. But, well it is a conversation that we need to continue.

Secretary McDONALD. Well, we do. Because we need to, as we have talked, we really need to talk about demand or requirements versus support. And—

The CHAIRMAN. And you talk about people coming to the VA because they like the VA and it delivers the best and the most quality healthcare. And you hear anecdotal evidence out there, too, that many veterans are going to the VA because you have no copays.

Secretary McDONALD. Well that is also true.

The CHAIRMAN. So I mean, that needs to be part of the discussion as well. Dr. Wenstrup.

Dr. WENSTRUP. Thank you, Mr. Chairman. And I thank you all for the hard work that you have put in here today. One thing I would like to address. Ms. Brown, I think in this committee there is no elephant in the room. I think that everyone wants to keep the VA up and running. But we can have the conversation about centers of excellence. And I do think that there are things specific to military duty that create the need for these centers of excellence. But we also talk about how veterans have so many comorbidities. We have to be able to address those as well, which is unique compared to a private practice. And I also feel that we can have what we call VHA providers, VA providers, outside the walls of the VA and sort of break down that stigma as you are not a VA doctor but you can be outside the walls. And I think we will all benefit from that.

I especially liked the analogy today about anatomy and physiology, that we may have too much anatomy and not enough physiology. You know, we can have a lot of, we can have a lot of anatomy but if the heart rate is 30 it does not really help much, right? So looking in that direction.

But really, Dr. Giroir, I appreciate what you have come here and talked about today because it is something I have been talking about for three years, really taking a look at how we do our business. And it is nice today, for example, that some of the things are going to DoD. But as someone who has been in VA and DoD, they have some of the same issues as far as productivity. Because I know as a practitioner and Reservist, I will see 50 patients in my practice but 15 in the DoD. And it is not because of comorbidities and sicker patients, necessarily. So there are some areas where that applies and others where it does not.

And so when we talk about increasing our numbers and we got more appointments, we have to take a look at what we are really doing. Are we just extending hours or adding more providers? Or are we actually increasing the productivity for the providers? And I think that that is a key component, and it sounds like we are talking about it.

And in the VA it is different, too, because most VAs are involved with education and training. That slows you down. There is no doubt about it. We all know that in our practices. But that, but still if we are talking about increasing to match the private sector to some degree, you know, eight percent, that sounds nice. But when we are talking 200 or 300 percent higher in the private sector, obviously there is a lot more we can do.

So I do applaud the decrease in wait times, the efforts being made, and actually finally having the frank conversation that I have been wanting to have for three years, of how we actually improve the capabilities of our providers all across the board.

One of the things that Dr. Abraham referred to, and you have heard me to refer it, Mr. Secretary, is about the RVUs. You inherited a system that really could not tell you what we are spending per RVU. And need to do that if we are really going to compare the cost of outside the walls of the VA and inside the walls of the VA. And until we can do that we really cannot make good assessments of what makes sense. We need to be able to assess our physical plants. I am encouraged to hear you say things like, yeah, if you are a doctor with one treatment room you cannot be productive. It just does not work. So we also need to look at total cost per RVU, then we can start looking at facility cost per RVU, whether it is a CBOC, or whether it is a hospital setting, and specific clinics per RVU. Then we can make some smart decisions.

So I guess the only question I really have is are we getting closer to being able to do that?

Dr. SHULKIN. Yes. Congressman, we do have RVU data. We have work RVU data. And work RVU data is directly comparable because it is the time and effort a physician puts in before, during, and after the visit. And so that is where we can show you the comparisons. It is not 200 or 300 percent difference, but you are correct. The private sector has higher RVUs than the VA. Several reasons for that that you have mentioned, our staffing ratios are far lower than they are in the private sector. We can begin to start getting at the cost issue but this is where it gets to is the work that we are doing in VA comparable to the work that is happening outside in the private sector, dealing with the pure physical components of care? But we are working towards that. Our commitment is to get the best value for the taxpayer and do the right thing for the veterans. So we are focused on efficiency and productivity, as well as quality of care.

Dr. WENSTRUP. Well when I talk about cost you understand I am talking about—

Dr. SHULKIN. Yes.

Dr. WENSTRUP [continuing]. The physical plant, the administrative costs, all those things. Because when you refer outside of the VA, you are not paying their malpractice and their physical plant. You are just giving that fee for what they did, similar to what Medicare does to a provider. And that is what we have to take into consideration. And I know that is a behemoth. But we really have to be able to look at those types of numbers to make logical decisions as we move forward. And I am talking about over the next decade.

Dr. SHULKIN. Yes. I agree with you. We are looking at those things. Medicare does reimburse on more than the work RVU. They reimburse on the total cost RVU, because there are three components to RVUs that are calculated when you are paid. And VA has different infrastructure requirements than the private sector. But I do believe that you are pushing us in the right direction to take a look at these issues and we are committed to doing that.

Dr. WENSTRUP. Thank you very much. I yield back. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. Ms. Brownley, you are recognized.

Ms. BROWNLEY. Thank you, Mr. Chairman. Mr. Secretary, good to see you again. Thank you to all of you for the hard work that

you have done to bring us this report and I apologize for being late. I was in another important hearing that I had to attend.

But I wanted to ask Dr. Giroir a question. The assessment refers to a longstanding truth in the veteran community, if you have seen one VA hospital you have seen one VA hospital. And of course we want to be as veteran-centric as possible. And certainly our veterans expect some level of standardization when it comes to not only intake but obviously their healthcare. So what are the most important recommendations, do you think, your report makes to ensure that veterans have a consistent experience within the VA system?

Dr. GIROIR. Thank you again for that question. I think it is a very important one. In addition to the four cornerstones I think a main principle here is, and again no veteran cares about what the average is. The veteran patient cares about the experience of that patient. But on average the VA does pretty well compared to the private sector. But the variability is tremendously wide. So there are fantastic, wonderful, national leading practices, but there are also VA medical centers that lag far behind the leading practices within the VA. And one of the recommendations that I think is obvious, or should be obvious and probably is obvious to the leadership panel, is there needs to be a transparent, open process to share best practices, to encourage innovation, that are in the VISNs. And if we focus on bringing the underperforming centers up to the level of the higher performing centers, you are going to have a system that is nationally, could be nationally leading and certainly comparable to the best ones. So one of the most important things is, yes, if you have seen one VA, you have seen one VA, and that has to change because a culture of best practices needs to be developed and shared. And that is one of the primary recommendations of the panel. And I see everyone shaking their head.

Secretary McDONALD. Well this was the number one requirement when David and I, when I was recruiting David for this position, is we simply have to do this. We have pockets of excellence but we have got to get everybody up to that standard.

The other thing we have to do is we have to do a better job with the employee experience, and I want to share this with you. Last week we took our top 300 leaders of VA offsite for training for three days. It is the first time they have ever been together for training, even though this is what you do in the private sector all the time. This is a map of the veteran experience for the C&P exam, compensation and pension exam. So there is technology that exists where you actually map the experience. You map the backstage, which is what is in the veteran's mind. You map the onstage, which is what happens when you work with them. And you map the backstage, which is what you do in the backstage to make sure they have a great experience. And then you design your facilities consistent with this. So we had people offsite, remember the first strategy of my VA is to improve the veteran experience. We are mapping these experiences and improving them using Lean Six Sigma in the backstage and using design thinking in the front stage. This is what the very best companies in the world do, and this is why we have to train people.

Ms. BROWNLEY. So will that be a benchmark, if you will, in terms of identifying the lower performing facilities?

Secretary McDONALD. Yes. This is a technology we were going to use to redesign our experiences in every facility across VA and then we will have, we will take the current best approach and we will make sure everybody does that current best approach.

The reason we started with the C&P exam is that is typically the worst experience a veteran and a VA employee can have and it is also oftentimes the first time VA touches a veteran.

Ms. BROWNLEY. And so do you have an identification now of the lowest performing, the best performing—

Secretary McDONALD. Yes. David can talk about that.

Dr. SHULKIN. Yes. I just want to reinforce what Dr. Giroir said. VA overall has lower mortality rates than the private sector hospitals do. VA overall has better patient safety rates than overall sectors do. But the variation is certainly there. And I think as Dr. Giroir suggested, if we could bring everybody up a level, and we saw 44 percent of our medical centers actually improve their quality metrics last year, we could have an extraordinary healthcare system. And that is what we are designing to do. So our metrics now identify high performers, low performers. We know that. We are working with the low performers to get their performance up. That is exactly where our focus is, one of my top priorities to identify best practices.

Ms. BROWNLEY. Thank you, and my time is out. I will yield back, Mr. Chairman.

The CHAIRMAN. Thank you. Dr. Benishek.

Dr. BENISHEK. Thank you—

The CHAIRMAN. I am sorry. I am sorry. Mr. Coffman.

Mr. COFFMAN. Thank you, Mr. Chairman. Secretary McDonald, the President recently signed into law a piece of bipartisan legislation that essentially transferred the VA's construction program for projects costing more than \$100 million to other agencies such as the Army Corps of Engineers. As you know, there have been billions of dollars of waste in the VA's construction management program that could have been diverted towards veteran healthcare and other benefits. Are there other areas that you could look at in the VA that is really not your core mission, like construction management, that could go to a private entity, such as claim processing for purchased care, something that TriCare and Medicare have been successful with?

Secretary McDONALD. Thank you for the question, Congressman Coffman. We are looking at that as part of our My VA transformation to see what it is we should do in our core business, what it is perhaps we should not do. But you know, the building thing is even more than that. I think, you know, if I look at the problems with the building and I include the Aurora facility, each one was designed as a one off. If Walmart builds a new store in Japan, that Walmart store in Japan looks very much like the Walmart store in the United States. As a result, if you transfer somebody from Walmart U.S. to Walmart Japan, they know how to operate in that store. So not only your construction costs less, because you keep building it, but your operating costs are less because people know how to operate in it. So one of the things we are doing with our

construction, and I know we are, you know, we have got to work with, we will work with the Corps of Engineers over \$100 million, is even what is under \$100 million is how can we go to a modular design so that every facility is built the same and we can transfer people from one to the other and they can operate? And importantly, our patients will know where to go. I mean, consumers love shopping in stores where they know how to navigate the store. So I think, I think there is a much bigger idea in construction than just giving it to the Corps of Engineers. I think we have more work to do.

Mr. COFFMAN. And I think also reviewing some of the requirements that you have in terms of force protection and other, you know, renewable energy requirements that are nice to have but that are over the top relative to what is done in the private sector. And I think, and clearly are driving costs as well.

Secretary McDONALD. Yes. As you know, those are federal laws, federal requirements—

Mr. COFFMAN. Right.

Secretary McDONALD [continuing]. And we will work with you on those.

Mr. COFFMAN. Okay. Mr. Giroir, I thank you. Would you like to comment as well on the, what could be outsourced from the VA that might be more effectively done?

Dr. GIROIR. Again, thank you for the question. And the report was fairly comprehensive, particularly in the business systems that need to be fixed one way or the other. For example, claims processing probably left almost \$600 million—

Mr. COFFMAN. Right.

Dr. GIROIR [continuing]. In reimbursement on the table from 2014. The lack of automation in reviewing bills from the private sector. If you want networks to come and private physicians to see VA patients, they expect at least at some point in time to get reimbursed for their services. So these are all aspects that we would hope there would be a critical analysis of either doing it in house or certainly there are precedents for outsourcing these kinds of business functions to get the efficiencies and ultimately divert that money back into patient care.

Mr. COFFMAN. Okay. The integrated report notes that VHA is in the midst of a leadership crisis according to this report. It said, quote, in almost every facility visited at least one leader interviewed mentioned that risk aversion and reluctance to, quote, unquote, speak up were a significant issue, unquote. This retaliatory culture permeates across all levels of VA and this committee has seen countless examples of retaliation against agency whistleblowers. Mr. Secretary, how are you dealing with the leadership crisis and the problems within the culture of the VA?

Secretary McDONALD. This is a big issue. Number one, we have got to get the leaders in place. Right now 90 percent of our medical centers have had a change in leadership, but we are committed to that. David can talk about that in a minute.

Number two is we have got to make it perfectly clear what kind of culture we want, and where we identify people retaliating against whistleblowers, we are disciplining them.

Number three, we have been working with the Special Counsel to make sure that the 45 or so whistleblowers get restitution in a positive way within our organization. And I met with the Special Counsel just this week and we discussed this. How can we do a better job of this?

Number four, we have been certified by the Office of the Special Counsel for doing the training that we need to do to improve on this.

Number five, town hall meetings. We have got to have town hall meetings. We have got to get the light shined on these kinds of things. We have got to listen to employees. And then importantly I also meet privately with the whistleblowers and the union leaders when I go to every site.

Dr. SHULKIN. Congressman, I would just add to what the Secretary said, we do have a crisis in leadership. We have too many open vacant positions. We have too many people in acting positions and interim positions. You cannot expect that you are going to have a transformation in a health system unless you have stable leadership in place. We need your help on this. We need your help to help create the VA to be an environment people want to come and serve and to be excited about. And we are asking for your help in Title 38 for the hybrid Title 38 to be able to help get the right type of compensation for leadership positions in VA. That will help us a lot.

Mr. COFFMAN. Okay, thank you. I think that one issue, and I will yield back, that we are divided on as a Congress, and I think you are all divided on as well, and that is the need for personnel reform. The need to be able to within the entire organization to fire those who are, to expeditiously get rid of those who are incompetent, those who are not performing, those who have committed fraud, to be able to get rid of them. It is simply too difficult. There is a, I think the principal problem in the culture of the organization is that it is too difficult simply to get rid of those who are not performing. Mr. Secretary, when you were at Proctor and Gamble clearly you did not have, I think you had a more balanced approach in that environment than exists here and it needs to change. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you. Dr. Benishek.

Dr. BENISHEK. Thanks.

The CHAIRMAN. You are welcome.

Dr. BENISHEK. I just want to touch on a few specifics that I think, that came to my attention from the report. And something you brought up, too, Mr. Secretary. And you mentioned, you know, using more leases to use the space. Well that just reminded me of the, you know, the CBOC that we are trying to expand in my district in Traverse City, and then the leasing process is like five years long. And you know, if there is a way that we can help you speed that up, because that is as long as a construction process. So I, and I know there is a lot of bureaucratic reasons for that but I think that is an issue that practically would help.

Secretary McDONALD. We agree. And we are now going through a Lean study on that process, and we will be back to you with the help we need.

Dr. BENISHEK. I am going to just kind of mention another issue, and that is about this nursing practice guidelines within the VA. You know, there is a lot of concern, you know, as a surgeon from the anesthesia department, independent practice of nurse anesthesia, there does not seem to be any additional information about nurse anesthesia safety versus the, you know, the family practice type nurse practitioners. I guess can you tell me what the situation is with that? I just want to make sure that our veterans are safe.

Secretary McDONALD. We put together a new nursing handbook which is now online for comment. I did get quite a few letters from members of Congress, particularly doctors, who thought that a nurse practicing anesthesiology was going too far. We have noted that on the website. On the other hand I have also gotten letters from nurse practitioners who say we should take full advantage. There are some studies available out there, one of which I think is a DoD study that says the safety is the same if not better. But I am out of my medical school. Let me let—

Dr. BENISHEK. Just let me know where you are at. Let me just go on to another issue. Dr. Shulkin, what exactly, can you give me an example of how you are taking the environment where we have this, some good hospitals and some good directors and some good processes, and then the variability? What have you done so far on the job, I know you just started a little while ago, to make this better? To get the best practices from one facility to another? Can you give me a specific thing? Because we have touched on this issue many times here in our discussions here, and I just want to get some ideas, specifically what have you done to make that better?

Dr. SHULKIN. Yes. As I mentioned before, we have a measurement system that we call SAIL, which is a metric system that puts together all of these quality measures so we can identify high performers and low performers. Then we are putting the high performers together with the low performers. We are actually going on site with the low performers and sitting down with their leadership team to make sure they understand what the data says, understand the reasons why they are not able to adapt to the best practices, whether it is hiring reasons, competency reasons, training reasons. And—

Dr. BENISHEK. What level are we talking about here now? Is this the department director? Or is this, I mean, can you give me a little more specifically—

Dr. SHULKIN. We have out of our central office, we have a quality organization that are led by physicians. Those physicians actually travel to the sites of the low performers. They bring the data. They meet all day with the leadership team. They set an action plan in place. And then they revisit whether there is improved performance. They are using what really the independent assessment has recommended, a continuous quality improvement process cycle but where we are setting goals and objectives. And we are using the strengths of the best practice sites to help teach the lower performers. And this is why we saw 44 percent of our medical centers make significant improvement over the last year.

Dr. BENISHEK. Well I just want to relate one anecdotal problem to you as long as I have your attention here, too. And that is I still have contacts within the VA system from physicians who relate to

me that they tried to improve, for example, the colonoscopy performance rate. And yet they are being pressured by the peer review process to not complain so that the discipline does not appear to be related to the complaints but to something different in their practice mode. And I just wanted to be sure that you are aware that that is going on. And I mean, I get a lot of complaints from VA physicians about that issue.

Dr. SHULKIN. Right.

Dr. BENISHEK. So I just wanted to bring that to your attention today.

Dr. SHULKIN. So I appreciate that. I have yet to meet doctors that are afraid to complain. So they are usually pretty good, particularly when it deals with patient issues. So I always encourage doctors to speak up and—

Dr. BENISHEK. Well, I mean, to me that is very important. Because we provide information that leads to better care and faster and more efficient care. And we just like to see those changes implemented rather than punished.

Secretary McDONALD. If you get those calls please have them call David or me and we would be happy to jump on them.

Dr. SHULKIN. Yes.

The CHAIRMAN. Gentlemen, thank you very much for being here today. Thank you for the work that you have all done, both on this \$68 million study. And Mr. Secretary, honestly, we thank you for what you do. Dr. Shulkin I think is a great partner in this process. I think you want to do the right thing. I think many of us are still concerned that the culture within the system is so hard to break. I do not know that there is a buy in yet at the mid-level. As it relates to construction of facilities, as you said, to build one in Japan versus on the United States, I think that is the appropriate, many schools do that so that they are all the same. And I just, you know, we want to be a partner in this process. We do have to look backwards in order to go forwards as well, and I know that is not what you would like to do. But we do not want to get into the mess that we found ourselves in over a year ago. This committee is in a bipartisan fashion committed to working together to give you the tools that are necessary to serve the veterans of this country.

Without objection all members would have five legislative days with which to revise and extend their remarks or add any extraneous material. And Ms. Brown would like to say something.

Ms. BROWN. Absolutely, Mr. Chairman. Let me thank the witnesses for being here. I want to thank the Chairman for agreeing to the committee taking a field trip to Denver Regional Complex Center. We have had lots of discussions and I think it would be good for the Committee to go and visit with the facility. I think it will be good to stop by New Orleans to see how the medical facility is progressing also. I am very interested in the last closing remark about you are on track concerning homelessness. One of the problems I found when I went to L.A., West L.A., is that 400 units have been vacant for over two years because the state did not have the funds even though we had provided the grant. So in those studies did VA or the state look at some of our partners, like different states, as VA moves forward? States holders play a vital role in making sure that we move forward with the veterans programs.

Secretary McDONALD. We have fixed that and in fact Mayor Garcetti recently announced I think it was \$100 million that he is putting against homelessness in L.A. If we do not fix the problem in L.A. we will not fix it nationally. So we are all laser-like focused on it.

Ms. BROWN. Thank you. Mr. Chairman.

The CHAIRMAN. Thank you, Ms. Brown. And for the record, I saw the Secretary's eyes get wide a second ago. I was not talking about a full committee field hearing out at the Denver regional facility. What I was doing was saying Ms. Brown is welcome to go out there any time she would like to. At this time, this hearing is adjourned.

[Whereupon, at 12:09 p.m., the committee was adjourned.]

APPENDIX

STATEMENT OF RANKING MEMBER CORRINE BROWN

Thank you, Chairman Miller.

Last year in the Veterans Access, Choice, and Accountability Act of 2014 we mandated that there be an Independent Assessment of veterans' healthcare. This morning's hearing is on the results of that Independent Assessment.

The Assessment highlighted many of the things we hear from our veterans. We hear that VA provides excellent healthcare, especially healthcare related to the special needs of our veterans. We also hear that in certain areas, VA is at the forefront of healthcare in this country.

We also hear from our veterans that VA care is often fragmented, and that it can be difficult to navigate and arrange non-VA care. We hear of long wait times and limited access.

For us on this Committee, the results of the Assessment are not new. Over the years we have seen a system become mired in bureaucracy and be required to do more when sometimes the resources to do more have not been made available.

What the Independent Assessment provides us with is a detailed, thorough, and fair look at where the Veterans Health Administration is, and the steps we must all take to get it back on the right track and focused on veterans.

What is clear is that if we are to meet our promises to our veterans, we must begin to look at reform. This reform must enable VA to focus on healthcare and operate, like the Secretary has previously stated, as a business. And the business of the Veterans Health Administration must be a clear and unwavering focus on the veteran patient.

The Independent Assessment points out that piecemeal fixes and legislation targeted at only one issue will not cut it. VHA needs a complete overhaul—from the way it schedules and delivers care to patients, to the way it treats its employees, to the way it partners with community providers.

It is approaching two decades since VHA last underwent a major reform effort. We must now begin the work of ensuring that VA healthcare is poised to meet the challenges of healthcare today, and the Independent Assessment will help us in that endeavor.

I look forward to hearing from the Secretary what steps he has taken to begin the reform process, and to hear from our other witnesses on how we can work together to ensure that the healthcare our veterans receive is the very best.

Thank you Mr. Chairman, and I yield back the balance of my time.

STATEMENT OF HON. PHIL ROE

I have been trying put together a summary of my experience with the Veterans Choice Program (VCP) and to get the perspective of both the VA and TriWest employees since they each blame each other. I am hoping somewhere in the middle lies the answer as to where the problems are occurring. Because I have been given so many different answers on how this step by step process works, I called the Non VA Care office at our VA Medical Center to talk to the people actually doing the work. One of the staff members, who was very receptive over the phone and had many examples to share, had planned to give me an outline of the process along with some of the problems they experience, but instead was told to refer me to Public Affairs, who cannot give the answers we need to solve problems.

There are two ways that a Veteran can become eligible for care under VCP provisions: (1) 30-day wait list and (2) Resides 40-miles or more from nearest VA medical facility. Most of the problems I see involve the 30-day wait list.

Below is information which has been given to me since the rollout of this program. In my experience, there appears to be a breakdown somewhere in this process but have been unable to get any clear answers on how to fix it. VAMC blames TriWest and TriWest blames VAMC.

- Eligibility is determined by VAMC/primary care doctor (if appointment is 30 days past the clinically indicated date)
- Non VA Care staff then uploads list of eligible veterans to VA's Central Office nightly & the veteran is told to wait 5–7 days and then call TriWest
- Central Office then sends the information to TriWest, which can take 3–7 days.

- Consults do not get submitted, medical documentation doesn't get uploaded, and authorizations get canceled leaving the veteran on a merry-go-round with VAMC & TriWest.

TriWest Perspective

The Veteran's servicing VAMC sends a notification to TriWest indicating that the Veteran has waited 30 days or is expected to wait 30 days or more for a specific type of care (podiatry, cardiology, neurology, orthopedics, dermatology, etc.). At the same time the notification is sent or soon after, the servicing VAMC sends a consultation to TriWest indicating what type of care the Veteran needs in the previously indicated specialty. Once these two criteria have been met, a TriWest patient services representative (PSR) contacts the Veteran to inquire about his or her appointment preferences and then searches for a provider that can meet the Veteran's needs in terms of appointment timeliness and a travel distance that falls within the VA's access to care standards. Once the appointment is made, the Veteran is notified and TriWest arranges for the provider to receive from the Veteran's servicing VAMC the appropriate medical records pertaining to the care being sought. An important thing to note regarding 30-day wait list notifications is that under this provision, the Veteran is only permitted to be appointed in the specialty for which he or she has been waiting 30-days or more for an appointment. If the provider the Veteran was appointed to see feels that additional care is needed, that provider must submit to TriWest a secondary authorization request (SAR) that TriWest would then forward to the Veteran's servicing VAMC for consideration. Any additional appointing depends on the VAMC response.

Network of physicians is a problem.

Need more staff.

VAMC perspective:

Non VA Care staff were given no training or SOP on this program and they are basically "winging it".

Our local Non VA Care staff was 5 – increased to 15 and still struggling to meet demands of thousands of appointments through the Choice Program. (There is talk of calling each patient for every appointment to make sure they want to keep it. If patient indicates they do NOT want to keep, VA staff will still be required to call them 2 times/mth until the appt. date has passed to make sure they haven't changed their mind. This will be a waste of resources they do not currently have.)

Outpatient clinics should be required to add patients to the electronic wait list rather than sending over to Non VA Care staff—this causes delays for the veteran

TriWest portal needs to be more user friendly for vendors; Secondary authorizations are a disaster.

Private doctors do not like jumping through all the hoops of the Choice Program & are saying they must give up a % of their fee to TriWest in order for TriWest to file their claim with VA.

Clinics (i.e. pulmonary, chiropractic) are closing at our VAMC because the doctors are fed up with everything going on.

Non VA Care staff believes putting the funding back into Non VA Care and out of the hands of TriWest will alleviate these problems.

**STATEMENT OF THE HONORABLE ROBERT McDONALD
SECRETARY OF VETERANS AFFAIRS
FOR PRESENTATION BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
OCTOBER 7, 2015**

Good morning, Chairman Miller, Ranking Member Brown, and Members of the Committee. Thank you for the opportunity to discuss the progress that Veterans Affairs (VA) has made in dealing with the challenges that came to light in the access crisis of 2014 and how far we have come. I am accompanied today by Dr. David Shulkin, Under Secretary for Health.

Many of the items on which we have made progress have been identified in the Independent Assessment of the VA's Health Care Delivery Systems, required in section 201 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146, "Choice Act"). The Assessment was delivered to Congress and the Commission on Care on September 1, 2015.

Caring for our Nation's Veterans and their survivors and dependents continues to be VA's guiding mission. As we emerge from one of the most serious crises the Department has ever experienced, we face continuing challenges in ensuring that Veterans receive the care they deserve and have earned through their service. We believe that these challenges are surmountable, and we will continue to work with Congress to resolve them and move forward in achieving our mission. We thank the individuals who worked for the last year on the Independent Assessment. The Assessment is a valuable instrument for validating the areas that require attention as we continue the transformation of VA.

VA's goal is always to provide Veterans with timely and high-quality care and services with the utmost dignity, respect, and excellence, and to provide timely access to clinically appropriate care in every case possible.

More than a year ago—at my Senate confirmation hearing—I was charged with ensuring that VA refocused on its sacred mission of caring for Veterans. I welcomed that opportunity. For the last year, we've been working with a great and growing team of excellent people to fulfill that sacred duty. VA employees have refocused on our CARE values of Integrity, Commitment, Advocacy, Respect and Excellence. Their work has significantly increased Veterans' access to care.

The recently released Independent Assessment, for the most part, reinforces our own analysis, and I am pleased to say we have already taken action on many of the recommendations it suggests. The Assessment also provides us with new ideas and helpful information that can and should inform how VA continues our transformation to a seamless, unified Veteran experience across the entire department.

VA has increased Veterans' access to care and completed approximately seven million more appointments over the past year (ending May 31, 2015) than in the previous year—2.5 million more at VA, 4.5 million more in the community. However, as we have improved access, Veteran demand has increased. Veterans are seeking more care from VA, causing a continuing rise in appointments over 30 days beyond the date the Veteran needed or wanted to be seen. The 7 million more appointments completed in the past year should have been twice as many as needed to eliminate all appointments over 30 days. Instead, appointments over 30 days have grown from 355,000 in October 2014 to 455,000 today. For their own reasons—including quality, convenience, and cost, enrolled Veterans are coming to VA for more care, more often. We've expanded the capacity required to meet last year's demand by focusing on four pillars—staffing, space, productivity, and VA Community Care.

First, we have more people serving Veterans. From August 2014 to August 31, 2015, Veterans Health Administration (VHA) has increased net onboard staff by over 14,000, including over 1,400 physicians, 3,800 nurses, 116 psychiatrists, and 422 psychologists. Included in this number are more than 7,700 medical center staff that VHA has hired as a direct result of the Choice Act enacted in August 2014.

Second, we have more space for Veterans. We activated over 1.7 million square feet in VA facilities last fiscal year and increased the number of primary care exam rooms so providers can care for more Veterans each day.

Third, we're more productive—identifying unused capacity, optimizing scheduling, heading off "no-shows" and late appointment cancellations, and extending clinic hours at night and on weekends. We're aggressively using technology like telehealth, secure messaging, and e-consults to reach more Veterans. Between June of last year and June this year, we completed 56.5 million appointments—a 4 percent increase over last year. There were 1.5 million encounters during extended hours, a 10 percent increase. Even with that increase in number of Veterans served, we completed 97 percent of appointments within 30 days, 92 percent within 14 days, 88 percent within seven days, and 22 percent the same day. For specialty care, wait times are an average of five days. For primary care, wait times are an average of four days and for mental healthcare an average of three days.

Fourth, we're aggressively using care in the community. The Veterans Choice Program (VCP) and our Accelerating Access to Care Initiative increased Veteran options for care for 13 percent more people than we did over the same period last year—a total of 1.4 million individual VA beneficiaries.

Following the 2014 access crisis, VHA developed the Blueprint for Excellence, strategies detailing how VA will evolve as a model national healthcare provider delivering both excellent health care and an excellent experience of care to all Veterans served. The Blueprint for Excellence is designed to improve access to healthcare, create a personalized "MyVA" experience for each of our Veterans, and streamline our system by making hundreds of VA-specific performance measures and reporting

requirements more consistent with those commonly used and nationally recognized in the healthcare industry.

The implementation of the Blueprint for Excellence's progress includes:

- Updated policies, procedures, and training to clearly define ethical leadership and associated behaviors;
- New Direct Secure Messaging partners and eHealth Exchange partners for increased virtual care;
- Evolving Patient Aligned Care Team (PACT) guidance, including care coordination, based on lessons learned from PACT Intensive Management evaluation;
- Implementation of over 700 Federally Qualified Health Centers provider agreements or contracts to increase Veteran access to clinical care;
- Continuing coordination of "Lean" efforts and cohesive strategic plan as aligned with MyVA; and
- Restructuring of VHA's Office of Medical Inspector processes and procedures to address both healthcare quality and individual/institutional accountability.

In short, we're putting the needs and expectations of Veterans and beneficiaries first, empowering employees to deliver excellent customer service, improving or eliminating processes, and shaping more productive and more Veteran-centric internal operations.

At the enterprise level, the work that is underway to transform Department operations also supports an effective response to the Assessment's findings and recommendations. MyVA is our transformation from VA's past way of doing business to one that puts the Veterans in control of how, when, and where they wish to be served. It is a catalyst to make VA a world-class service provider. It will modernize VA's culture, processes, and capabilities to put the needs, expectations, and interests of Veterans and their families first. The MyVA vision provides a seamless, unified Veteran Experience across the entire organization throughout the country.

To provide advice to me and the MyVA Task Force, we stood up a MyVA Advisory Committee (MVAC) in the Spring. The Committee has been and is providing advice on completing short-term and long-range plans, priorities and strategies to improve the operational functions, services, processes and outputs of the Department, and advice on appropriate levels of support and funding necessary to achieve objectives. Further, the Committee has been and is reviewing how we are implementing recommended improvements and will suggest any necessary course corrections. The individuals serving on this Committee, led by Chairman Joe Robles, the former President and Chief Executive Officer of United Services Automobile Association, come from a wide range of backgrounds in customer service, large-scale organizational change and advocacy for Veterans. MVAC is having its third meeting next week.

The main effort of the MyVA transformation concentrates on a relatively small set of efforts focused on five priorities:

- Improving the Veteran's experience. At a bare minimum, every contact between Veterans and VA should be predictable, consistent, and easy. But we're aiming to make each touch point exceptional. To make the right changes in how we operate, we are currently applying Human Centered Design techniques to examine our processes from the Veteran's perspective. Some examples of how this revised thinking will effect healthcare delivery:
 - Based upon employee suggestions solicited by the MyVA process, we've executed pilot programs at Bay Pines, FL; Mountain Home, TN; and White River, VT, to allow Veterans to see audiologists and optometrists without first seeing a Primary Care provider. The results of these pilots will inform revised processes across the Nation, enhancing access to both specialists and primary care mentioned in Assessments D and E.
 - We are taking steps to improve our digital and telephonic experiences with Veterans. We will roll out the initial version of a new website on Veterans Day, www.Vet.gov that will begin the process of consolidating our confusing websites. Likewise, we are developing a strategy for an enterprise approach to streamline our disparate collection of 1-800 numbers. Enhancing our self-service capabilities and ensuring our contact centers can answer questions on the first call will help address some of the access issues Assessments D and E raise.
 - Our goal is to provide leaders and employees throughout VA with an objective means of assessing and improving their organization's ability to deliver customer experiences that instill trust in VA. To learn what that is, we have been benchmarking what the "best in class" customer experience businesses and organizations do, and will introduce customer service goals for our front-line staff in 2016.
- Improving the employee experience. To deliver an exceptional Veteran experience, we must have empowered and engaged employees. VA employees are the foundation of VA, serving with distinction each day. They provide care, information, and access to earned benefits. Improving the employee experience requires focusing on employees at every level.
 - To begin the process of changing our leadership culture and resolving issues around priorities and strategic direction identified in Assessment L, we have launched a "Leaders Developing Leaders" program. The initial effort with the Department's most senior leaders began in August, and in September we started the cascading process with 300 of VA's field leaders. Field leaders are the "tip of the spear" for cultural change and as such, we need to address this population earliest. In last week's training of our 300 top field leaders, we focused our efforts on customer service and improving Veteran experience through the lens of developing leadership judgment, analyzing the enterprise, teambuilding and team feedback, and managing change. Field leaders will learn how to conduct action learning workshops, cascade VA and team goals, develop other leaders, and advance leadership philosophies. I plan to continue the

cascade of "leaders developing leaders" training across VA in fiscal year 2016. Our aim is simple - to teach VA field leaders the skills that will ensure the success of MyVA and the realignment of business processes so that we may fulfill our obligations, put Veterans first and deliver excellent customer service.

- To start this effort, we hired a global expert in training leadership, cascading strategy, enabling and empowering employees, and building organization capability. This is what business does. Noel Tichy, Professor at the Ross School of Business at the University of Michigan, author of many best-selling books on leadership and strategy, past mentor of Jack Welch at The General Electric Company (GE), and creator of GE's training university at Crotonville, is working with us in this effort. We have no hope of improving the Veteran experience if we don't first invest in improving the employee experience.
- The cascaded training is not the only way we are working with our staff to better the Veteran experience. To ensure all of our employees have a baseline of knowledge about VA benefits and services to share with Veterans, we have instituted VA101 training, a course developed and implemented by employees.
- We continue to develop an enhanced customer-service training program to enable and empower frontline employees to better serve Veterans. We have too many training modules that are not driven by what experience the customer actually wants or what the employee can deliver. We can deliver better customer service through consistent training to front-line employees and supervisors that empowers them to do the right thing for their customers.

While improving Veteran and employee experiences are central to our efforts, three complementary efforts will help build more robust management systems, enhance productivity, and deliver more effective results.

- Achieving support services excellence allows employees and leaders to focus on assisting Veterans rather than worrying about "back office" issues such as information technology (IT), procurement, staffing, supplies, and facilities management. We have completed as-is assessments of our IT, human resources, acquisition, and financial management operations. We will now work to develop end-to-end process improvements, with initial focus on medical supply chain and critical staffing shortages.
 - For the sixth year in a row, J.D. Power and Associates has reported that our Consolidated Mail Outpatient Pharmacy had the highest Customer Satisfaction Index score among the country's private and public mail-order pharmacies, and VHA's Pharmacy Benefits Management office has been recognized for its efficiency and ability to share knowledge at facilities across VHA.
- Establishing a culture of continuous performance improvement requires proven strategies to help employees examine their processes in new ways. To build continuous improvement into VA, we have chosen the team-based performance

improvement methodology known as Lean as our performance quality management system. We are expanding Lean and Six Sigma training to employees to empower them and enable them to change the processes to improve Veterans' experiences. We'll use these methodologies extensively to address the findings in the Independent Assessment.

- Enhancing strategic partnerships will allow us to extend the reach of services available for Veterans and their families. We're making it easier for federal, state, and local government, as well as private sector organizations, to partner with VA by standardizing our partnership processes. For example, we have facilitated establishment of 23 Community Veterans Engagement Boards (CVEB) around the country with a target of 50 CVEB by the end of this calendar year. Better communications and relationships with local communities, academic institutions, and providers will facilitate access and improve care.

Many issues outlined in the Assessment are complex, and solving those problems will require both a systems approach and a true partnership with all of VA's stakeholders. We are moving out and will continue to act aggressively to resolve those issues that are within our control.

Over the last year, we've worked together with Congress to address Veterans' access needs. We are grateful for the close working relationship we have had, particularly with this Committee. The Independent Assessment noted, "VHA has the opportunity to achieve a place among the highest performing health care systems in the world. It will be the charge of Congress, the Commission on Care, and VA leadership to see that these recommendations and resulting transformation efforts are given the necessary attention and support that they—and our nation's Veterans—deserve."

The Independent Assessment's Blue Ribbon Panel called on "Congress and the VA" to address these barriers. We need your help to follow through on many of the recommendations and provide adequate resources to address the growing number of services provided as well as the increased demand for those services.

It's now clear that the access crisis in 2014 resulted in large part from a significant mismatch of supply versus demand, exacerbated by greater numbers of Veterans receiving services. Rebalancing this incongruity will take time and courage. Rebalancing will include

- Addressing statutory issues that have created needless red tape and bureaucracy;
 - As we detail below, there are critical needs to address in areas related to our Care in the Community programs and authorities.
- Helping VA divest itself of underutilized or inefficient facilities and reinvest in facilities that will provide the best return on the investment in serving Veterans;
 - For example, VHA has 25 million square feet of underutilized space and 6.5 million square feet of vacant space that take resources for upkeep. With 60 percent of our buildings over 50 years old, these facilities do not

incorporate new models of care and cannot be easily adjusted to use our PACT model.

- Strengthening the appeal of senior leadership positions with hiring and compensation flexibility. VA has previously requested special pay authority for VA Medical Center and Veterans Integrated Service Network (VISN) Directors to help VA recruit and retain the best talent possible in hospital system management;
- Establishing leadership continuity by extending tenure for key positions; and

Services and benefits peak years after conflicts end, and healthcare requirements and the demand for benefits increase as Veterans age and exit the workforce. Full funding of the 2016 budget request is a critical first step in meeting these challenges, but we have to look much further ahead for the sake of Afghanistan and Iraq Veterans.

2016 Budget and Legislation

To meet these growing requirements, VA needs the adequate funding the President's Fiscal Year 2016 budget request provides. The House-proposed \$1.4 billion reduction to VA's total request, including allocation of a Department-wide rescission, means \$688 million less for Veterans Medical Care—the equivalent of as many as 70,000 fewer Veterans receiving care. The Senate's proposed reduction to VA's total budget request would be \$857 million.

Further, the House proposal would provide no funding for four Major Construction projects and six cemetery projects. Our growing requirements are a clear signal that even greater challenges lay ahead, and we can't afford to be shortsighted. I am greatly concerned that the House-passed funding bill cuts construction by 50 percent at a time when 60 percent of our buildings are over 50 years old and general operating rooms today must be at least 50 percent larger than they were about a decade ago. To illustrate this point, Assessment K of the Independent Assessment highlights the huge deficit between our recapitalization requirements and projected funding availability.

We were grateful for your enactment of the VA Budget and Choice Improvement Act in late July to provide flexibility to the end of Fiscal Year 2015 to apply appropriated VCP funds to greatly increased demands for Care in the Community programs, as well as special needs for Veterans with Hepatitis C which reflect pharmaceutical advances of unquestioned benefit for Veterans with the disease. But we believe flexibility among Care in the Community programs should be extended into the future.

That there is more that can be done to remedy artificial, and we believe arbitrary, restrictions that impede delivery of care and benefits. There are over 70 line items in VA's budget that dedicate funds to a specific purpose without adequate flexibility. These include limitations within the same general areas, such as healthcare funds that cannot be spent on health care needs, and funding that can only be used for one type of Care in the Community program and not others.

The Independent Assessment also expresses concerns with budget inflexibility in VA health programs that result from the current appropriations structure and process. Additionally, the Independent Assessment recommended there be more flexibility for aligning resources with Veterans' demand for care.

In line with our requests this year to look at ways to consolidate the various types of Care in the Community programs and authorities, the VA Budget and Choice Improvement Act also calls for improving Veterans' access to community care by streamlining community programs into a new VCP. We will deliver that plan to Congress on November 1, 2015. Leading industry practices, feedback from Veterans, employees and stakeholders, and alignment with VA's future vision for healthcare will inform the New VCP design. The new program will standardize Veteran eligibility, authorization, provider networks, care coordination, claims management, and the integration of current authorities into one consolidated program.

VA presented in its FY 2016 President's Budget a number of other ideas for legislation to enhance VA efficiency. There are numerous proposals, but one especially helpful proposal is a measure to end an arbitrary 80-hour per Federal work period requirement that is simply not appropriate or efficient for many medical professionals, and is certainly not imposed in the private sector. The current requirement creates needless complications in hospitals, especially emergency room settings. Current law, which does not allow flexibility for medical professionals to work, for example, 100 hours in one pay period and 60 in the next, is a mismatch for the 24/7/365 environment of healthcare today. No private sector hospital would institute this rule, for good reason. The effect makes shift coverage difficult and makes it harder for VA to recruit and retain critical professionals. We strongly encourage enactment of this legislation.

On May 1, VA transmitted to Congress an Administration draft bill, the Department of Veterans' Affairs Purchased Health Care Streamlining and Modernization Act. Additional proposals that will streamline and unify VA's purchased care authorities will be out later this year as a result of the plan and recommendations required by section 4002 of the VA Budget and Choice Improvement Act. However, the Administration's May 1 proposal is still essential to clarify key legal issues and end uncertainty about certain aspects of purchased care—including long-term care—that are outside the VCP and create complications with providers in VA's other Care in the Community programs. We urge Congress to act on this proposal; we have already begun to see nursing homes fail to renew their agreements with VA, resulting in Veterans having to find new facilities for residence. We believe this basic clarification of VA non-contract purchase authority is needed now, and can create momentum for further consolidation of Care in the Community programs.

VA appreciates Congress' passage of the Continuing Resolution, which enables us to continue to deliver timely, high quality care and benefits to our Veterans. The passage of the CR, combined with Congress' ongoing commitment to providing advance appropriations for our medical care accounts, enable our dedicated employees, one-third of whom are Veterans themselves, to remain at work to deliver care, reduce the claims backlog, conduct interments for Veterans and dependents, and

help hundreds of thousands of Veterans. However, the protracted and frequent use of continuing resolutions is an inefficient way for the Federal government to operate.

We look forward to passage of the President's Budget, which provides the adequate funding that VA needs.

Conclusion

Mr. Chairman, the recommendations of the Independent Assessment and the forthcoming Commission on Care represent opportunities for VA to build upon ongoing work to transform the Department and for the government to reaffirm its commitment to Veterans' health care. As the Veterans of Foreign Wars noted in their "Our Care" report released on September 22, 2015, "After reading through [Veterans] responses, the VFW believes that veterans ultimately believe in the VA healthcare system and believe that they have earned the right to take advantage of a healthcare system designed exclusively to meet their unique needs."

We look forward to continuing our work with Veterans, Congress, VA community care providers, Veteran Service Organizations, and our own employees to ensure that VA delivers great healthcare outcomes for Veterans. The last year has shown that there is a tremendous willingness and readiness for organizational change. Our employees want to share their strengths and the passion they bring every day to deliver healthcare to Veterans. But, we can only do so much on our own; as we have detailed above, we need your help to continue to develop our capabilities and adapt to meet Veterans' needs. We recognize the need to address our issues with urgency; I hope you will join us in renewing our commitment to our Nation's Veterans and delivering them their healthcare system.

Thank you. We look forward to your questions.

**STATEMENT OF RICHARD J. BYRNE
TO THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ON THE SUBJECT OF THE
"INDEPENDENT ASSESSMENT OF THE HEALTH CARE
DELIVERY SYSTEMS AND MANAGEMENT PROCESSES
OF THE DEPARTMENT OF VETERANS AFFAIRS"
OCTOBER 7, 2015**

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Chairman Miller, Ranking Member Brown, and distinguished members of the committee, I appreciate the opportunity to submit a statement in support of today's hearing on *The Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*. My name is Richard Byrne, and I am a Senior Vice President of The MITRE Corporation. MITRE is a not-for-profit company chartered in the public interest to address issues of critical national importance and as such operates under a set of rules and constraints prescribed by the Federal Acquisition Regulations to preserve its objectivity, independence, and freedom from conflict of interest.

Introduction: The Independent Assessment was conducted under the auspices of the Centers of Medicare and Medicaid Alliance for Modernizing Health, a Federally Funded Research and Development Center operated by MITRE, and in partnership with The RAND Corporation, McKinsey & Co., and Grant Thornton. We also set up an independent Blue Ribbon Panel composed of 16 top private sector health care executives to further review and critique our work to ensure that the best practices of the private sector were incorporated.

The Independent Assessment includes a broad, evidence-based set of findings and recommendations. It reveals that there are four pervasive systemic issues that, together, significantly contribute to large variations in performance and result in unacceptable Veteran experiences. It is our belief that the only way to successfully transform VHA to eliminate these variations in a sustainable and scalable manner is to address those four findings using an integrated systems approach.

Background: Section 201 of the Veterans Access, Choice, and Accountability Act of 2014 required an Independent Assessment of the hospital care, medical services, and other health care furnished in medical facilities of the Department of Veterans Affairs (VA). The Act specifically directed that assessments be conducted in 12 areas, covering a broad spectrum of Veterans Health Administration (VHA) services, operations, and support (Figure 1). The findings and recommendations from these assessments revealed interrelationships that demand a holistic understanding of VHA.

VHA's health care delivery system is challenged by a unique combination of factors including its significant scale and scope, unique patient population, and congressionally mandated funding, governance, and oversight. VHA operates one of the country's largest and most complex organizations, with 1,600 care sites (including 167 medical centers) across 50 states, currently staffed by approximately 300,000 employees who cared for nearly six million Veterans last fiscal year. VHA is a major research and teaching

Figure 1
Veterans Choice Act Assessments

- | |
|----------------------------------|
| A. Demographics |
| B. Health Care Capabilities |
| C. Care Authorities |
| D. Access Standards |
| E. Workflow – Scheduling |
| F. Workflow – Clinical |
| G. Staffing/Productivity |
| H. Health Information Technology |
| I. Business Processes |
| J. Supplies |
| K. Facilities |
| L. Leadership |

organization, with a \$1.2 billion annual research budget. Its health professional education program is the nation's largest, clinically training nearly 120,000 individuals each year via affiliations with more than 1,800 educational institutions.

Approach: The Independent Assessment was performed by interviewing VA employees and outside observers, visiting 87 VA sites, conducting multiple surveys, analyzing 560 data sets provided by VHA and data from other sources, and performing literature reviews. In addition, best practices were gathered from the private sector through interviews with top health care executives, site visits to high-performing health care organizations, and consultation with an independent advisory panel of nationally recognized health executives and stakeholders (Appendix Q: Blue Ribbon Panel). This approach not only provided deep understanding of the 12 assessment areas, but additionally provided a comprehensive view of VHA. It is VHA's interdependent system that is the focus of the findings and recommendations in the Integrated Report.

The Independent Assessment: The Independent Assessment includes an Integrated Report and the 12 major assessment reports for the areas designated in Figure 1. Each area is addressed in a separate assessment report that includes findings and evidence-based recommendations (Appendices A–L and Volume II). The Integrated Report builds upon the findings and recommendations of those reports and identifies the four systemic findings that must be addressed to enable a sustained transformation of VHA.

Significant Flaws: While VHA exhibits a deep commitment to serving Veterans, many of the assessment teams consistently found that VHA's health care facilities deliver strikingly different patient experiences, apply inconsistent business processes, and differ widely on key measures of performance and efficiency. The assessments also provided evidence that the organization is plagued by many problems: growing bureaucracy, leadership and staffing challenges, and an unsustainable trajectory of capital costs. Other reports and assessments have pointed to local failures of access and quality. On the other hand, there are bright spots throughout VHA that illuminate best practices that work effectively within the VHA environment. Understanding the various aspects of these differences sets a context that can allow VHA to identify and act on opportunities for continuous sustained improvement.

Systems Approach: VHA must adopt systems thinking to address its most challenging problems, including access, quality, cost, and patient experience.¹ Systems thinking is a framework for solving problems based on the premise that a component part of an entity can best be understood in the context of its relationships with the other components of the entity, rather than in isolation. It takes into account the interdependencies of the parts to find the best combination of strategies that meet the needs of the whole. This approach is required to address the interdependent nature of the people, processes, and technologies supporting VHA. This approach has been well established in many industries, including health care, and often enables leaders to reframe the problem into opportunities based on an appreciation of how components of the program should be working together, as opposed to how they are currently interacting. Systems thinking does not promote tackling individual problems independently

¹ This information is informed by the Institute of Medicine Assessment D (Access Standards) in Volume II.

because the solutions—more often than not—will be sub-optimal, non-scalable, and non-sustainable.

While complex problems benefit greatly by reframing problems in creative ways, systems solutions also work well for improving existing processes and motivating people to believe they can successfully change. Continuous improvement is one such approach that often uses a Plan-Do-Study-Act cycle that identifies, reduces, and eliminates suboptimal processes for continuous incremental or breakthrough improvements. This approach relies heavily on measuring, analyzing, and experimenting for successful innovations. The current culture in VHA would benefit greatly from instituting continuous improvement more effectively so that everyone participates, sees progress, and can build on the pride they have in being part of VHA. Some of VHA's best performers already focus on continuous improvement, but it is not widely adopted as a standard way of operating. Transforming any organization, especially one the size of VHA, requires that everyone understands, feels accountable for, and acts daily on how to continuously improve the organization. It is as much about engaging the people as it is about fixing the processes.

Four Systemic Findings: A review of the extensive evidence, findings, and recommendations in the assessment reports—informed by an analysis of industry benchmarks and best practices, insights from health care executives and high-performing health care systems, and interactions with Veterans Service Organizations—enabled the identification of four systemic findings that impact mission execution.

- A disconnect in the alignment of demand, resources, and authorities
- Uneven bureaucratic operations and processes
- Non-integrated variations in clinical and business data and tools
- Leaders are not fully empowered due to a lack of clear authority, priorities, and goals.

The recommendations that will enable VHA to address these findings are discussed below. These recommendations are interdependent and must be coordinated and implemented via a systems approach to improve the VHA system overall.

Finding 1: A disconnect in the alignment of demand, resources, and authorities

VHA's mission—"Honor America's Veterans by providing exceptional health care that improves their health and well-being"²—is inspirational and widely accepted by VHA staff, but there are significant geographic variations with respect to how the mission is translated into action for individual Veterans. Complex eligibility rules make determining which Veterans are covered and which services those Veterans receive a challenge, and navigating VHA is often difficult for Veterans—a problem exacerbated by incomplete guidance and non-standardized business processes. Furthermore, the growing role of outside providers has not been effectively integrated into VHA's operating model, which is based on providing direct care within VHA facilities.

² U.S. Department of Veterans Affairs. Veterans Health Administration. "About VHA." [Website]. Retrieved from <http://www.va.gov/health/aboutVHA.asp>

At present, VHA is over-committed in some geographic areas, given its broad mission, an expanding list of automatic eligibility criteria, and limited resources. Matching supply and demand at the local level is challenging because supply is relatively fixed each year once service projection models allocate resources to each facility through the appropriation and budgeting process.

Although the population of Veterans is expected to decline by 19 percent over the next decade,³ the demand for health care services is expected to rise before it levels off in five years, based on demographic factors (primarily aging)—and likely will rise even more if access to VHA health care is improved (Assessment B [Health Care Capabilities]). On the other hand, in some areas and for some health conditions, VHA may not have a sufficient population of patients to sustain highly specialized service lines with enough volume to achieve and maintain clinical excellence.

Recommendation 1—GOVERNANCE: Align demand, resources, and authorities.

Congress, the Commission on Care, and VA leadership should address the misalignment of demand with available resources both overall and locally. They should align VHA's goal to provide comprehensive health care to Veterans with VHA's capacity by adjusting capacity or reshaping the expected benefit—that is, the Veteran population to be served (eligibility) on the one hand, and the health care those Veterans will be provided (service lines) both by VHA and by community resources on the other.

Supporting Recommendations

- **Establish a governance board to develop fundamental policy, define the strategic path, insulate VHA leadership from direct political interaction, and ensure accountability for the achievement of established performance measures.**

Congress should consider the following alternatives for such a governance board:

- Charter a commission modeled after the 1955 U.S. President's Commission on Veterans' Pensions.
- Empower a board or commission to reshape geographic service areas and optimize facilities resourcing and lines of service (along the lines of the Defense Base Realignment and Closure Commission process used for military installations).
- Assign the definition of the governance board as a mission for the Commission on Care, established under Section 202 of the Veterans Choice Act.
- Whatever approach is selected, ensure that the solution focuses on governance, that members have sufficient longevity of term, and that the authorities of the board are fully endorsed by Congress.

- **Require a patient-centered demand model that forecasts resources needed by geographic location to improve access and to make informed resourcing decisions.**

VHA should:

- Effectively explore predictive tools to continually forecast local demand and fine-tune estimates of required resources.

³ This information is presented in RAND Corporation Assessment A (Demographics) in Volume II.

- Reallocate and manage resources flexibly to meet national, regional, and local variations in patient-centered demand.
 - **Clarify and simplify the rules for purchased care to provide the best value for patients.**⁴
- VHA should:
- Develop a stronger management structure for purchased care and allocate responsibility and authority to the most appropriate levels.
 - Establish an ongoing process for evaluating third-party administrator performance.
 - Develop clear and consistent guidance and training on VA's authority to purchase care.
 - Ensure that both new and existing purchased care contracts with outside providers and third-party administrators include appropriate requirements for data sharing, quality-of-care reporting, and care coordination.

Finding 2—Uneven bureaucratic operations and processes

Several centralized operational and support functions appear to have lost customer focus and do not adequately support the needs of the medical centers. In response, individual VA Medical Centers (VAMCs) have adopted local implementations of certain processes, but many of these were found to be unnecessarily complex and, not surprisingly, inconsistent across VHA. In many cases, these centralized and local process issues have become inefficient or bureaucratic and have had a direct and negative impact on the overall Veteran experience and timely access to care.

These widely varying processes highlight the complexity of VHA within the larger, equally complex VA organization. Severe problems may manifest themselves at one facility, while another constantly receives tributes from Veterans and health care experts. The oft-quoted reminder, “if you’ve seen one VA hospital, you’ve seen ONE VA hospital,” captures this reality.

Recommendation 2—OPERATIONS: Develop a patient-centered operations model that balances local autonomy with appropriate standardization and employs best practices for high-quality health care.

As Assessment L (Leadership) suggests, VA and VHA should streamline their Central Offices and strengthen poor-performing support functions. VHA should adopt systemic means to identify, assess, disseminate, adapt, and scale best practices throughout the system—whether these practices originate inside or outside of VHA.

Supporting Recommendations

- **Right size and reorient the VHA Central Office to focus on support to the field in its delivery of care to Veterans.** This implies a series of actions to include reassessing all VHA Central Office-directed metrics and policies to ensure that they add sufficient value to patient outcomes and eliminate those that do not.

⁴ This information is derived from RAND Corporation Assessment C (Care Authorities) in Volume II.

- **Fix substandard processes that impede the quality of care provided to the Veteran.** This is clearly dependent on, among other efforts, implementing an operating model that provides medical centers with the autonomy and flexibility to innovate and address local needs while also providing standardization across the system.
- **Design and implement a systematic approach to identify best practices and disseminate them appropriately across the enterprise.** This approach would include defining the role of the Veterans Integrated Service Network (VISN) to lead the best-practice identification and to share ideas within and across the enterprise, working collaboratively with VAMC leaders and staff.

Finding 3—Non-integrated variations in clinical and business data and tools

A lack of common, integrated VHA enterprise systems and tools negatively impacts VHA's operations and resulting data. Inconsistent and ineffective data collection and analysis undermines rapid, evidence-based assessment and improvement of quality and customer satisfaction. VHA lacks a holistic, enterprise approach to collecting and leveraging its data. Data interchange with the Department of Defense (DoD) and external health care providers is limited, which creates unnecessary clinical risk. Since newly discharged Veterans often become VA patients, interoperability with DoD is necessary and expected. These shortfalls hinder using available data to support effective decision making and performance management.

Recommendation 3—DATA AND TOOLS: Develop and deploy a standardized and common set of data and tools for transparency, learning, and evidence-based decisions.

Supporting Recommendations

- **Use standardized clinical and administrative data for accuracy and interoperability.**
- **Implement a single, integrated set of system-wide tools centered on a common electronic health record (EHR) that is interoperable across VHA and with DoD and community providers.⁵**

Specifically, VHA should implement and integrate one system-wide:

- EHR system that is interoperable across the entire system and with DoD and community providers
- Electronic claims payment system to pay for outside services
- Billing system to collect from other payers
- Patient-friendly scheduling system with modern, single toll-free-number call-center support
- Set of electronic clinical decision-support tools describing standard work, protocols, and guidelines housed in an electronic medical library.
- **Transparently share performance metrics for leadership, clinical, and business functions across VHA to identify and adopt best practices for continuous improvement.**

⁵ This information is derived from The MITRE Corporation Assessment H (Health Information Technology) in Volume II.

Finding 4—Leaders are not fully empowered due to a lack of clear authority, priorities, and goals

As Assessment L indicates, VHA leaders operate within a challenging and disempowering environment that discourages emerging leaders from seeking promotion within the organization. While VHA has seen a 160-percent growth in headquarters program office staff in the past five years, key field leadership positions throughout the organization sit vacant or are staffed with acting leaders, and more than half of executives are eligible for retirement, potentially creating a larger number of vacant positions. Further, a misalignment of accountability and authority exists within a broader VHA culture characterized by risk aversion and lack of trust. Those leaders who are effective too often achieve outcomes despite the challenges of the organization within which they operate.

Recommendation 4—LEADERSHIP: Stabilize, grow, and empower leaders; galvanize them around clear priorities; and build a healthy culture of collaboration, ownership, and accountability.⁶

VHA must resolve the leadership crisis by putting the right leaders in the right jobs with the right skills under an appropriate governance model for the appropriate amount of time.

Supporting Recommendations

- **Push decision rights, authorities, and responsibilities to the lowest appropriate level throughout the organization.**
- **Build on Veteran-centered behaviors to drive a culture of service excellence, trust, continuous improvement, and healthy accountability.**
- **Revitalize the leadership pipeline through establishment of enterprise-wide, comprehensive succession-management and leadership-development functions.**
- **Strengthen the appeal of senior leadership positions by pursuing flexibilities in hiring and compensation.**
- **Establish sustained leadership continuity by extending tenure for key positions.**

A Call for System-Wide Change: The Independent Assessment highlighted systemic, critical problems and confirmed the need for change that has been voiced by Veterans and their families, the American public, Congress, and VHA staff. Solving these problems will demand far-reaching and complex changes that, when taken together, amount to no less than a system-wide reworking of VHA.

Several high-performing health care organizations were examined by the study team, including Kaiser Permanente, Virginia Mason, Geisinger Health System, and the Cleveland Clinic. Although all of these are of a differing scale than VHA, all overcame significant clinical or economic troubles by making consistent, organization-wide changes that enabled them to transform themselves into organizations that now excel at their specific missions. Similarly,

⁶ This recommendation and the ideas expressed in the supporting recommendations reflect information provided in McKinsey & Company Assessment L (Leadership) in Volume II.

during 1994 to 1999, sustained leadership within VHA deployed system-wide changes that effected a major transformation of the agency's operations. VHA should once again commit to that level of systemic change.

A system-wide transformation is required, based on an integrated systems approach that acknowledges the interdependence of the four systems recommendations:

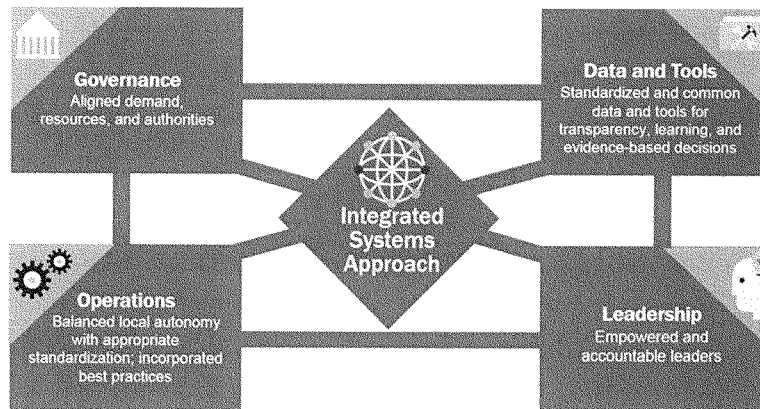
- 1) **Governance:** Align demand, resources, and authorities.
- 2) **Operations:** Develop a patient-centered operations model that balances local autonomy with appropriate standardization and employs best practices for high-quality health care.
- 3) **Data and Tools:** Develop and deploy a standardized and common set of data and tools for transparency, learning, and evidence-based decisions.
- 4) **Leadership:** Stabilize, grow, and empower leaders; galvanize them around clear priorities; and build a healthy culture of collaboration, ownership, and accountability.

These four recommendations create the integrated systems cornerstones, as shown in Figure 2.

With these four interdependent systems components successfully in place, VHA will have the opportunity to achieve a place among the highest performing health care systems in the world. As an example of the value of this systems approach, consider the challenges that VA faces in managing its capital program in facilities management. As Assessment K (Facilities) highlights, provided that average funding levels remain consistent over the next 10 years, the \$51 billion capital requirement would significantly exceed the anticipated funding level of \$16–26 billion.⁷ Not only would this shortfall jeopardize the capital program, it would also threaten the financial integrity of the entire VHA health care delivery system and, in turn, significantly impact the quality of health care provided to Veterans. Viewing this primarily as a funding problem would be shortsighted. Rather there are interdependent findings in each of the four cornerstones that need to be addressed in an integrated fashion to achieve a sustainable solution. In terms of governance, external constraints limit VHA's ability to deliver and operate medical facilities at the level of private-sector benchmarks; investments in facilities are not effectively linked to workload growth; existing space is not being used at its highest efficiency; and expected funding levels do not support identified capital needs.

⁷ This information comes from McKinsey & Company Assessment K (Facilities) in Volume II.

Figure 2
Integrated Systems Cornerstones



As Assessment K also reveals, for operations, total cost of ownership is not calculated or integrated into capital planning decisions; VHA has no integrated system to manage the entire leasing process; comprehensive tracking or measurement of the leasing program and its outcomes is precluded; and a large majority of facilities noted challenges in hiring staff and filling vacant positions. For data and tools, data capture occurs at multiple levels and through multiple tools, generating multiple sources of truth about the status of the capital program; tools for developing Strategic Capital Investment Plan business cases rely on user creativity and capabilities to consider creative alternatives to capital solutions; and systems do not consistently capture key performance indicators, and the metrics are not standardized across all stakeholders. And for leadership, there are recognized shortfalls in overall accountability, role clarity, personal ownership, internal communication, and proactive problem-solving approaches that limit VA's and VHA's ability to deliver the correct projects on time and on budget; the broader culture of facilities functions is characterized by silos and risk aversion, resulting in an inability to consistently advance projects in an efficient manner; and competition for limited funds has led leaders to make a range of choices in developing projects that favor approval strategies over efficient project delivery.

Viewing these facilities challenges through the lens of the integrated systems approach begins to reveal the complexity of the problem, the integrated nature of the required transformation, and the opportunity to reframe the facilities challenges as part of a larger set of interdependent pieces of VHA's overall health care system. Facility challenges can be significantly mitigated by a transformative realignment throughout the capital program deploying best practices in leasing and contracting; realigning the strategy of the capital program to improve project selection, optimize the infrastructure portfolio, implement innovative care delivery models, understand demand-based needs, and explore and partner with purchased-care opportunities; and

reevaluating funding requirements. In short, employing the systems view could help reframe the vision for future health delivery and significantly reduce VHA's current and future capital investment issues. It also positions VHA not to be burdened long term with hospital overcapacity as the nature of health care delivery trends toward smaller inpatient facilities, increasing outpatient care, and more virtualized health care delivery.

The richness of the systems approach extends not just to facilities, but across many of VHA's biggest challenges. Patient access to clinician appointments cannot be sustainably addressed by only focusing on increasing overtime in the near term without looking at demand modeling, improving scheduling processes and tools, and a number of other dependencies. Choice Card funding is critical to increase purchased care access, but will not succeed without strong Veteran navigational aids, clearer rules of use, and a number of other cultural and leadership changes to promote using health care services outside of VHA. Prioritizing these findings and then solving them individually is tempting, but such an approach would not guarantee a sustainable solution. As H.L. Mencken stated, "For every complex problem there is an answer that is clear, simple, and wrong."

There are clear obstacles. As the assessment reports reveal, the number of issues VHA currently faces appears overwhelming. In its current state, VHA is not well positioned to succeed in the transformation that this analysis suggests. Three essential actions are required to realize the recommendations inherent in this transformation. VHA must:

- Recognize that the four cornerstones are interdependent and the success of any one of the four overarching recommendations hinges on the implementation of the other three. These solutions must be coordinated and implemented via a systems approach to improve VHA overall.
- Establish a transformation program management office with authority and funding (redirected from current central and local funding mechanisms) to implement the system-wide reworking of VHA. This will include establishing priorities, defining timelines for execution, allocating resources, and instituting appropriate metrics for success. It should merge relevant components of MyVA, the *Blueprint for Excellence*, and other ongoing initiatives into one coherent, focused transformational approach.
- Require evidence-based systems models to inform and implement integrated solutions that balance governance, operations, data and tools, and leadership.

It will be the charge of Congress, the Commission on Care, and VA leadership to see that these recommendations and resulting transformation efforts are given the necessary attention and support that they—and our nation's Veterans—deserve.

**STATEMENT OF BRETT P. GIROIR, MD
TO THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ON THE SUBJECT OF THE
"INDEPENDENT ASSESSMENT OF THE HEALTH CARE
DELIVERY SYSTEMS AND MANAGEMENT PROCESSES
OF THE DEPARTMENT OF VETERANS AFFAIRS"
OCTOBER 7, 2015**

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Chairman Miller, Ranking Member Brown, and Members of the committee, thank you for the opportunity to provide testimony regarding the Independent Assessments required by Section 201 of the Veterans Choice Act. My name is Dr. Brett Giroir; I am currently Senior Fellow at the Health Policy Institute of the Texas Medical Center in Houston, Texas, and the founding CEO of Health Science and Biosecurity Partners. I am a critical care physician by training, and have previously served in several leadership roles in Texas and nationally, including service as the CEO of the Texas A&M Health Science Center, Director of the Science Office at DARPA (Defense Advanced Research Projects Agency), and Director of the Texas Task Force on Infectious Disease Preparedness and Response. I am honored to appear before you today as Chair of the Blue Ribbon Panel created by the MITRE Corporation to provide support, oversight, and guidance for this independent assessment.

The Blue Ribbon Panel was composed of sixteen distinguished and outspoken experts whose names and brief biographies are listed in Appendix Q of the Integrated Report. Among the Blue Ribbon Panelists were the former CEOs of Kaiser Permanente, Geisinger, and HealthCare Partners; the Physician-In-Chief of Massachusetts General Hospital; a former Surgeon General of the Army; the world's leading academic authority on organizational change; the President and CEO of the National Quality Forum; the former Executive VP of United Health; a former Vice Chief of the US Army; the Webb Professor of Health Innovation at Arizona State University; the President and CEO of the Texas Medical Center; the former President and Chief Executive Officer of the California HealthCare Foundation; the Dean of the Jefferson College of Nursing; a Board Member of national Patient-Centered Outcomes Research Institute; and former Director of Medicare and Medicaid Services. More important than these objective qualifications is that each Blue Ribbon Panel member shared a deep commitment to our Veterans; and nearly all shared personal or family experiences interacting with the Veterans Health System.

Although not specifically required by the Choice Act, the independent Blue Ribbon Panel was fully involved from the onset of the assessment, with complete access to raw data, subcontractor project teams, subject matter experts, and MITRE senior management. We reviewed thousands of pages of data and drafts, engaged in numerous conference calls, and spent four 2-day sessions in highly interactive meetings at MITRE headquarters. We facilitated data collection, provided frequent and candid feedback, and worked collaboratively with MITRE to develop final priorities and recommendations while maintaining our Panel's full independence. Ultimately, as indicated by our

letter included in the Preface of the Integrated Report, the Blue Ribbon Panel members unanimously endorsed the Integrated Report and its findings and recommendations.

As the Members of the Committee have read, the Report contains numerous near-term operational recommendations, few of which were unexpected. For example, enhanced physician productivity – a key component to enhancing access for Veterans - will require more exam rooms, increased clinical support staff, improved patient scheduling, and greater authority granted to clinic directors for overall resourcing.

But more importantly, the Report also offers recommendations to solve deeper root-cause issues that have persistently plagued the VHA, and have prevented the successful implementation of reforms that were already suggested by the 137 previous VHA assessments. As MITRE has already testified, these root-cause issues are the basis of four overarching recommendations in the areas of Governance, Leadership, Operations, and Data and Tools that must be solved using an integrated systems approach. Addressing each of these four overarching recommendations is essential before any long term, sustained improvements in access, patient experience, and quality of care can be realized.

Indeed, even the example I just gave of improving physician productivity appears straightforward, but would require reform of unnecessarily bureaucratic clinical staff hiring processes, which take three times as long as the private sector; empowerment of VA medical center leadership to flex resources to meet dynamic patient access needs; commitment to a modern electronic scheduling system that transparently indicates appointment availability to both schedulers and patients alike; and overhaul of the facilities construction and leasing processes that now cost twice as much as the private sector but proceed at a pace that is two- to three-fold more slowly.

I will briefly describe these four overarching areas in more detail from the perspective of the Blue Ribbon Panel. This perspective was recently highlighted in a lead article appearing on September 30, 2015, in the New England Journal of Medicine, entitled “Reforming the Veterans Health Administration: Beyond Palliation of Symptoms.”

First, the VHA must establish a governance model that is representative, expert, relatively insulated from direct political interactions, and empowered with the necessary authority to improve quality, patient experience, personnel management, data validity, and cost-effectiveness. One of the most

urgent strategic priorities is to determine and clearly communicate the future mission of the VHA, and for Congress to align resources and authorities to meet that specific mission. As background, in 2014, 9.1 million of 21.6 million U.S. Veterans were enrolled in the VHA. Of these, only 5.8 million were actual VHA patients; and on average, these patients relied on VHA for less than 50% of their health care services. Much of that reliance was driven by a lack of health insurance — a driver that is now diminishing due to federal and various state initiatives.

These demographic data combined with access challenges suggest reconsideration of whether the VHA should aim to be *the* comprehensive provider for all Veterans' health needs — or whether the VHA should evolve into more focused centers providing specialized care, while utilizing non-VHA health care networks for the majority of Veterans' health care needs. Either paradigm could be highly beneficial to Veterans, as long as demand and resources are prospectively aligned, and there is a consolidation of current programs to simplify access to non-VHA providers. Under any future allocation scenario, however, the Panel believes there must be a region-by-region evaluation of Veterans' current and predicted health care needs in the context of both VHA and non-VHA health care capabilities. This evaluation may result in the elimination of some VHA inpatient beds, expansion of VHA or non-VHA outpatient or community resources, an increasing emphasis on non-VHA providers, or some combination of adjustments to assure access to high quality and cost-effective care.

Second, the VHA is currently experiencing a crisis in leadership because of an organizational environment that is perceived as disempowering, frustrating, and occasionally toxic. The VHA scored in the bottom quartile on every measure of organizational health assessed in the Report. VHA leaders believe that they are accountable for quality and patient satisfaction, but have little authority or flexibility to achieve their objectives. Risk aversion and mistrust within the VHA further inhibit innovation and demoralize otherwise passionate and committed professionals. Compensation for administrators is frequently 70% below that in the private sector. As a result, at the time of our assessment, 39% of senior leadership teams at VHA medical centers had at least one vacancy; and 43% of network directors had “acting director” status. Sixteen percent of VHA medical centers lack a permanent director. Moreover, more than two thirds of network directors, nurse executives, and chiefs of staff are eligible for retirement, as are 47% of medical center directors.

The solution, we believe, is multidimensional but starts with immediate changes in practice that will ultimately change culture to one that is Veteran-centric and committed to continuous improvement.

The VHA must push decision rights, authority, and responsibilities down to the lowest appropriate administrative level. The VHA must increase the appeal of senior leadership positions by pursuing regulatory or legislative changes that create new classifications for VHA leaders, and develop a robust leadership training and succession plan that nurtures future leaders in an environment that values honest assessments.

Third, the VHA must develop a patient-centered operations model that balances local autonomy with appropriate standardization, and shares best practices for high quality health care, patient experience, and cost-effectiveness throughout the VHA national system. The VHA Central Office's recent growth (by more than 160%) has not improved performance. In fact, the VHA scores in the bottom quartile in 35 of 37 management practices as compared with peers assessed for the Report. We recommend a shift in VHA focus from central bureaucracy to supporting clinicians and administrators in the field, and a clear articulation of what decision authority resides at each level of the organization. Performance metrics should be meaningful to the Veterans, simple to understand, objective, and numerically much fewer. Most importantly, a systematic approach is needed for identifying and disseminating best practices. The Report highlights many examples of leading VHA regional and site-based practices, for example a number of innovative programs from VISN 4 that have significantly improved patient flow, enhanced staff engagement, enabled review of quality in real time, and instituted novel collaborative partnerships with regional academic centers to ensure availability of inpatient beds.

Fourth, the VHA lacks fundamental enterprise systems and data tools that are required to achieve high-quality care and patient satisfaction in a cost effective manner. Once cutting edge, the Veterans Health Information Systems and Technology Architecture (VistA) electronic health record (EHR) has been stagnant for a decade, and clinicians are frustrated with the lack of integration and mobility and feature deficits as compared with commercial systems. Moreover, the existence of approximately 130 different variations of VistA impedes system changes and dramatically inflates costs. Indeed, 85% of the VHA's FY16 Information Technology budget is allocated to maintenance of the current systems, with scarce remaining funding for IT and software improvements or replacements. Furthermore, VistA's lack of interoperability with Department of Defense systems introduces unacceptable risk into transitions of care, both for highly complex care such as PTSD, TBI, and severe traumatic injuries, but also routine health care of patients with chronic medical conditions.

VHA systems for patient scheduling, staff hiring, supply-chain management, billing, and claims payment are stagnant, lack automation, and have more limited capabilities than their private-sector equivalents. During our study period, the Panel has witnessed that data aggregation across the VHA is highly problematic, requiring enormous manual efforts by highly skilled teams, and data validity is still often impossible to verify.

Veterans consistently complain about the lack of patient-centered navigational tools that are generally available in most non-VHA integrated health systems. We believe that the VHA must provide these fundamental tools to clinicians, local administrators, and to Veterans. Moreover, the VHA should immediately perform a comprehensive evaluation of whether it should continue high-cost custom development and maintenance of VistA, or implement a commercial EHR and associated business and management systems.

Finally, on behalf of the Panel, I would like to express our appreciation to the hundreds of experts who contributed to this Report, and to the literally thousands of contributing Veterans and VHA employees who believed that this Report would become a roadmap to achieve the highest quality of care for Veterans, at a cost we can afford, and in a culture that would be the envy of any health care system in the nation. I would also like to express our gratitude to this Congressional Committee for your support of Veterans and our Panel, and for the opportunity to answer any questions related to our assessments and recommendations.

**STATEMENT FOR THE RECORD
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO
PROVIDED TO THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES**

**A CALL FOR SYSTEM-WIDE CHANGE: EVALUATING THE INDEPENDENT ASSESSMENT
OF THE VETERANS HEALTH ADMINISTRATION
OCTOBER 7, 2015**

Chairman Miller, Ranking Member Brown and Members of the Committee:

The American Federation of Government Employees, AFL-CIO and its National Veterans Affairs Council (AFGE) thank you for the opportunity to present our views on the Mitre Corporation's independent assessment of the Veterans Health Administration. AFGE represents more than 220,000 employees of the Department of Veterans Affairs, more than two-thirds of whom work in VHA medical facilities. AFGE's comments focus on Volume I's Executive Summary and Staffing/Productivity section.

COMMENTS ON STAFFING/PRODUCTIVITY (APPENDIX G)

A comparison with the private sector must take into account the special needs of almost all VHA patients, not just dentistry. The other major difference between VHA and the private sector is VHA's focus on the *whole patient*, and all his or her medical and psychological needs, rather than on the one condition that is initially presented.

Official panel size numbers are deceptive; providers regularly see walk-ins, unassigned patients, and patients whose providers are on leave or no longer with the VA. (As the report notes, VA needs to do a much better job of managing daily staffing variances.) Front line providers are frequently subjected to

arbitrary panel size increases; AFGE recently received a report of the psychiatrist workload *doubling* at one facility.

In addition, provider schedules rarely include set-aside time for the hours spent on indirect patient care duties (computer alerts, lab reports, and other tasks), some of which fall to the provider because of lack of support personnel. Coordination with non-VA care has also significantly increased VA provider workloads.

As one VA provider reported, “We are compared with outside providers who often have RNs and PAs, readily available exam rooms, more admin authority over exam orders and functioning electronic medical records and PACS (imaging).”

OTHER COMMENTS

(Page xi): “VHA’s health care delivery system is challenged by...its significant scale and scope [and] unique patient population”.

Comment:

VHA’s size and unique patient populations are VHA’s greatest *advantages*; they are the reason why the VA is the best source of veterans’ care in the country and why the VA leads the nation in best practices, research and training. AFGE has received troubling field reports from VHA employees about undue pressure to send patients out to Patient-Centered Community Care (PC3) provider networks even when timely, high quality care and better care coordination are available in-house. This pressure puts patients at risk, especially in light of the recent VA Office of Inspector General finding that “inadequate PC3 provider networks were a major disincentive to using PC3 because it increased veterans’ waiting times, staffs’ administrative workload, and delayed the delivery of care”. (Report No. 15-00718-507, September 29, 2015)

Overreliance on non-VA care also threatens the long term viability of the entire VA health care system. As former VA Secretary Principi stated last year: “The VA system is valuable because it is able to

provide specialized health care for the unique medical issues that veterans face, such as prosthetic care, spinal-cord injury and mental-health care. If there is too great a clamor for vouchers to be used in outside hospitals and clinics, the VA system will fail for lack of patients and funds, and the nation would lose a unique health-care asset." (*Wall Street Journal*, May 29, 2014)

(Page xii): VHA transformation:

In order for *every* employee to understand and be engaged in continuous improvement, managers have to transform their own hostile attitudes toward the input of front line clinicians and support personnel. Joint labor-management discussions about quality improvement at the local level are the exception, not the norm, according to our member reports. VHA needs an incentive program that rewards *all* employees for innovative ideas, not just managers.

(Page xiv): Governance Board:

VHA was transformed into an exemplary health care system in the 1990s through ongoing labor-management partnerships. Through collaboration they achieved major improvements in clinical care, information technology, patient safety and workplace culture. It is essential that this governance board have a formal, permanent seat for employee representatives.

(Page 34): VHACO Size – What *really* needs to be counted:

The finding that VHA central office staff has increased by 160% is valuable but does not tell the whole story. In order to rectify this distortion in the workforce and better serve the agency mission, we need to look less at where people work (since there are too many managers in nonclinical positions in the VISNs and medical center) and look more at whether they are performing *direct* clinical care functions rather than medical administration functions.

(Page L-6): Redesigning the hiring process: AFGE regularly solicits suggestions from front line VHA employees on ways to streamline the hiring process. The following are some of the suggestions we received regarding VHA hiring:

- Have an applicant pool ready and in place when new vacancies occur, rather than first posting jobs after vacancies occur.
- Shorten the credentialing process so it only gathers the most pertinent information, and does not require the same information already collected by licensing boards.
- Curb the widespread practice of hiring clinicians and support personnel “off the books” without job postings; cronyism has worsened during the current hiring surge.
- When a VA provider transfers to another VA facility, he or she should not have to go through full credentialing again.
- When hiring officials break promises they made during the hiring process (e.g. recruitment incentives, loan assistance, desirable schedules), they lose new hires and the large financial investment involved in bringing them on board. These “bait and switch” practices are well known outside VHA and therefore discourage colleagues in the same professions from applying.
- Applicants are also discouraged by VHA’s “7422” policy that deprives Full Title 38 clinicians (e.g. physicians, dentists, registered nurses and physician assistants) of the same bargaining rights and protections against arbitrary management actions afforded to other VHA employees and clinicians at other federal agencies.

Finally, legislation to strip VA employees of civil service protections against manager retaliation and other arbitrary and prohibited personnel actions (including unsubstantiated career-destroying performance evaluations and allegations of patient neglect) is extremely destructive to VHA’s ability to recruit and retain a strong workforce. As University of Maryland Professor Donald Kettl testified at a recent Senate Veterans’ Affairs Committee hearing: “We can’t fire our way to success”. Rather, success can be within reach if Mitre’s recommendations are implemented through meaningful collaboration between management, labor, veterans’ groups and other stakeholders.

Thank you for the opportunity to present AFGE’s views on this important report.



Reserve Officers Association of the United States

House Committee on Veterans' Affairs

**A Call for System-Wide Change: Evaluating the Independent Assessment
of the Veterans Health Administration**

October 7, 2015

"Serving Citizen Warriors through Advocacy and Education since 1922."™

Reserve Officers Association
1 Constitution Avenue, N.E.
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The Reserve Officers Association of the United States (ROA) is a professional association of commissioned, non-commissioned and warrant officers of our nation's seven uniformed services. ROA was founded in 1922 by General of the Armies John "Black Jack" Pershing during the drawdown years following the end of World War I. It was formed as a permanent institution dedicated to national defense, with a goal to teach America about the dangers of unpreparedness. Under ROA's 1950 congressional charter, our purpose is to promote the development and execution of policies that will provide adequate national defense. We do so by developing and offering expertise on the use and resourcing of America's reserve components.

The association's members include Reserve and Guard Soldiers, Sailors, Marines, Airmen, and Coast Guardsmen who frequently serve on active duty to meet critical needs of the uniformed services. ROA's membership also includes commissioned officers from the United States Public Health Service and the National Oceanic and Atmospheric Administration who often are first responders during national disasters and help prepare for homeland security.

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Lt. Col. Susan Lukas, U.S. Air Force Reserve (Ret.)	202-646-7713

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Reserve Officers Association is a member-supported organization. ROA has not received grants, contracts, or subcontracts from the federal government in the past three years. All other activities and services of the associations are accomplished free of any direct federal funding.

On behalf of our members, ROA thanks the committee for the opportunity to submit a statement on section 202 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), to examine the access of Veterans to health care from the Department of Veterans Affairs (VA).

Organization of the Veterans Health Administration (VHA)

Of the nation's 22 million living veterans, VA provides health care for some 7 million patients, a 20 percent increase from 2009. The VA provides care for this one-third portion of the U.S. veteran population through its Veterans Health Administration (VHA), with a staff of more than 289,000 employees at more than 1,600 sites, including 167 medical centers, 1,018 community-based outpatient clinics, 300 vet centers, and 135 community living centers.

ROA agrees with Secretary of Veterans Affairs McDonald's plan to merge the three administration's regional centers into consolidated regional centers. This will allow assistance to be given on benefits and health issues at one location. This consolidation would present VA the opportunity to reduce headcount and also to redirect staff to improve the agency's performance where it lags. ROA could envision such "excess" staff being retrained and going to process benefits claims, where there is a shortage that has generated an increase in claims appeals. Staff selectively chosen for their integrity and interest in advocacy could perhaps provide internal oversight and investigations to ensure compliance with policies and procedures. VA could also redirect staff to manage strategic implementation. Some regional staff should focus on best practices and innovative change, to spread positive efforts system-wide.

Some or all of these initiatives might be met with well-intentioned opposition by the unions; in fact this is an opportunity for the unions to participate in substantively enhancing veterans' health care and benefits. These changes could contribute to better accountability for VA which is critical to quality care.

Location of health care resources

What is unclear is how much care is delivered for service-related disabilities and how much is delivered for non-service related disabilities. These are key factors in VHA's consideration in how it deploys resources. As a subset of service-related versus non-service-related care, VA must gather and assess data on the levels of care provided to better understand where they should focus resources. Health care is provided on several levels.

1. Primary care: health care provided by a medical professional (as a general practitioner or a pediatrician) with whom a patient has initial contact and by whom the patient may be referred to a specialist for further treatment (Merriam Webster's medical definition).
Primary care is the first level of contact between patients and physicians and medical care

providers. Primary care providers generally comprise primary care practitioners, nurse practitioners or physician assistants dealing with issues such as diagnosing mild healthcare issues or dealing with mild and sometimes acute medical problems. Most primary care problems are for back pain, skin care, osteoarthritis and joint disorders, lipid metabolism disorders, and upper respiratory tract disorders. Emergency medical care is also considered primary care. Excluding emergency care, primary care can be provided in a clinic, community center or hospital. Primary care physicians are also in charge of coordinating healthcare provision since they refer patients to various specialists for specialized treatment.

2. Secondary care: medical care provided by a specialist or facility upon referral by a primary care physician that requires more specialized knowledge, skill, or equipment than the primary care physician has available to them (Merriam Webster's medical definition). Examples of such specialists are cardiologist, endocrinologist, neurologist, etc. Secondary care is primarily delivered in hospitals or special facilities where medical specialists are housed.
3. Tertiary care: highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities (Merriam Webster's medical definition). Tertiary care is almost exclusively delivered in hospitals given the need for advanced medical technology and the intensity and frequency of care.
4. Quaternary Care: Highly specialized care including experimental medicine. The distinction between tertiary and quaternary care can be blurry since quaternary care is in some ways an extension of tertiary care. Quaternary care is not offered at many medical facilities and is quite rare.

If data indicates service-connected disabilities require more secondary care, VA could determine if they have the right type and number of facilities and staff to provide such care. Beyond secondary care, veterans may need more extensive tertiary care if these service-related conditions become exacerbated and require intensive care and hospitalization. Since the veteran population includes a significant senior population (45.8% of the veteran population are 65 and older), hospitalization is more likely than the general population. Consequently, VA medical centers could also direct their resources to providing in-patient care for more intensive treatment.

VA is uniquely situated to collect data and fund research for veteran-related ailments. This research component of VA's mission justifies directing resources to quaternary care. Quaternary care tends to be more experimental and is more highly specialized than tertiary care. This experimental care can sync well with VA's mission to research ailments and disabilities that disproportionately affect the veteran population. These conditions may not always be properly

treated in civilian medical facilities. Thus, VA can provide this highly specialized quaternary care at its facilities to fulfill this need in the veteran community. VA's groundbreaking work would inevitably enrich the health care sector's ability to help the populace.

VA has seen outpatient visits increase significantly since 2002, according to the following table; but without differentiating service connected versus non-service connected visits, it's hard to determine if resources are being appropriately used.

Selected Veterans Health Administration characteristics: FY2002 to FY2013

Fiscal Year	TOTAL ENROLLEES ¹	OUTPATIENT VISITS ²	INPATIENT ADMISSIONS
	(in millions)	(in millions)	(in thousands)
2002	6.8	46.5	564.7
2003	7.1	49.8	567.3
2004	7.3	54.0	589.8
2005	7.7	57.5	585.8
2006	7.9	59.1	568.9
2007	7.8	62.3	589.0
2008	7.8	67.7	641.4
2009	8.1	74.9	662.0
2010	8.3	80.2	682.3
2011	8.6	79.8	692.1
2012	8.8	83.6	703.5
2013	8.9	86.4	694.7

¹ Includes non-enrolled Veteran patients.

² Includes fee visits.

Source: Department of Veterans Affairs, VHA, Office of Policy and Planning

Prepared by the National Center for Veterans Analysis and Statistics.

Deliver health care to Veterans during the next 20 years

Who

Regardless of soothing pronouncements by political leaders wishing to anesthetize the public preceding a war (declared or – as is distressingly now uniformly the case – undeclared) conflict will generate military buildup; and its partial or complete conclusion will slough off spending, equipment, and the service of human beings.

Many of those human beings will have been physically and mentally impaired in the enterprise; the need to provide benefits and services to veterans will not go away.

In each decade the military services have continuously been involved in military engagements as shown below.

1939-1945	World War II (and subsequent Berlin crisis and airlift)
1950-1953	Korea, Taiwan, Lebanon
1965-1973	Vietnam, Bay of Pigs, Laos, Zaire
1980-1989	Iran, El Salvador, Libya, Sinai, Lebanon, Egypt, Honduras, Persian Gulf, Panama
1990-1999	First Gulf War, Bosnia, Kosovo, Liberia, Sierra Leone,
2001-Present	Second Gulf War: Afghanistan, Iraq, ISIL

One could argue that the services will never again grow to the size experienced during World War II and the Cold War, but despite reduced military end strengths, during our lifetimes, the need for veterans' care and benefits will not abate. The buildups of the past two or three generations will generate VA enrollments for decades. Two major drawdowns occurred with the end of the Cold War and the reduction of forces to Iraq and Afghanistan, yet increases in the disability rating groups continue.

While there may be fewer veterans, with the loss of our Second World War generation and the passage from us of those who served in the Korean and Vietnam wars, those entering the VA system since Vietnam have presented more disabilities than those of previous generations.

According to VA, "From 2009 to 2013, the average number of issues included in a disability claim increased from 2.8 to 4.9. In particular, VBA has noticed an increase in complexity of the claims from the newer generation of Veterans who participated in Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn. These young heroes have a greater chance of surviving serious injuries and often return home with multiple amputations, blindness, burns, multi-organ system damage, and most notably, with the signature wounds of the war -- traumatic brain injury (TBI) and posttraumatic stress disorder (PTSD). In addition, VBA continues to receive complex claims from Veterans of the Vietnam Era, who submit more claims than Veterans from any other period of service." VA testimony on December 4, 2013 by Mr. Tom Murphy, Director, Compensation Service.

The following table shows the increase in veterans with service connected disabilities and the increase in number of disabilities resulting in higher ratings.

Service-connected Disabled Veterans by Disability Rating Group: FY2002 to FY2013

Fiscal Year	Total Veterans with a Service-Connected Disability	0 to 20 percent	30 to 40 percent	50 to 60 percent	70 to 100 percent
2002	2,398,287	1,209,274	527,820	266,886	394,307
2003	2,485,229	1,204,038	546,157	287,978	447,056
2004	2,555,696	1,200,715	558,306	304,341	492,334
2005	2,636,979	1,199,271	573,994	324,637	539,077
2006	2,725,824	1,207,358	594,765	345,832	577,869
2007	2,844,178	1,229,001	621,440	371,622	622,115
2008	2,952,285	1,237,868	643,882	398,679	671,856
2009	3,069,652	1,244,230	665,211	427,902	732,309
2010	3,210,261	1,258,882	689,599	459,657	802,123
2011	3,354,741	1,258,987	711,305	492,692	891,757
2012	3,536,802	1,266,501	729,813	532,192	1,008,296
2013	3,743,259	1,281,492	749,531	572,421	1,139,815

Source: Department of Veterans Affairs, VBA; 1999-2013: Annual Benefits Reports

Prepared by the National Center for Veterans Analysis and Statistics.

Congress and VA must use the number of veterans, the number of visits, and the types of conditions to determine the services required for the next 20 years. In the past it appears future needs were forecast using the current number of veterans, resulting in an overtaxed system unable to meet health care in a timely manner. Likely compelled by a toxic mix of political and budgetary pressure from the incumbent administration and VA's own cultural blinders, VA senior executives consistently low-ball future needs. VA thus resists expansions of care, such as it did with Agent Orange, ALS (until then-Secretary Anthony Principi boldly decreed a service connection), Gulf War illness, and the entire issue of battlefield toxicity.

VA must recognize that it can resist the reality of Veteran needs only so long: history shows that it ultimately loses, forced by public will – at great loss to its prestige and goodwill – to provide Veterans the care promised in its own motto. The agency, for example, must factor into its planning the complications that will occur from the loss of limbs as a result of the Iraq and Afghanistan veteran cohort's aging. Advances in health care must also be considered as part of future increases in resources. Recently, VA was unable to estimate the cost of new Hepatitis C drug therapies and had to go back to Congress for additional funding. Gene therapy and stem cell research will more likely identify "cure" approaches, which could result in higher cost than the treatment-centered medicine of today.

What

The health care industry's development is being driven by technology as much as dollars. It is easy to say that VA care in the next 20 years will use many of these advances. The harder part will be deciding how much VA should invest in new technologies versus what should be contracted for, shared in partnerships with other providers, or leased; this calculus includes the often staggering costs of use: training, infrastructure support, and maintenance.

The rise of outpatient care indicates a growing appetite for mobile health care. Such care can be in part provided by evidenced-based apps that can prescribe, aid in making diagnoses, applications for case management, and apps that track medical conditions. In addition to the use of apps, the ability to use video is becoming part of our everyday environment. Such new, but already mainstreaming technologies as "telemedicine" overcome distance and provider scarcity, have been shown to be accepted by patients, especially younger patients, and would potentially facilitate the reduction of unnecessary brick and mortar.

Where

According to VA (www.ruralhealth.va.gov/about), *"Currently, 3.2 million rural veterans are enrolled in the VA system. This represents 36 percent of the total enrolled veteran population based on the 2010 U.S. Census. Men and women veterans from geographically rural areas make up a disproportionate share of servicemembers and comprise approximately 31 percent of the enrolled Operation Enduring Freedom and Operation Iraqi Freedom [OEF/OIF] veterans, many of whom return to their rural communities."* Placing this into context, the 2010 census shows 16 percent of the U.S. population lives in rural areas.

The use of technology to overcome distance for rural veterans has already been discussed above; however, it could also be addressed through mobile health clinics and vet centers that have regular prescribed destinations. Veterans have clearly shown a preference for mobile Vet Centers.

Recently, Congress noted in Senate Report 114-057, *"The Readjustment Counseling Service is composed of over 2,200 employees in 300 Vet Centers, 80 Mobile Vet Centers, and the Vet Center Combat Call Center. The Committee remains strongly supportive of these programs and notes the number of Vet Centers or Mobile Vet Centers is not expected to increase despite an increasing workload. In fact, VA estimates it will continue to operate the exact number of Vet Centers in fiscal year 2017 as it did in fiscal year 2014."*



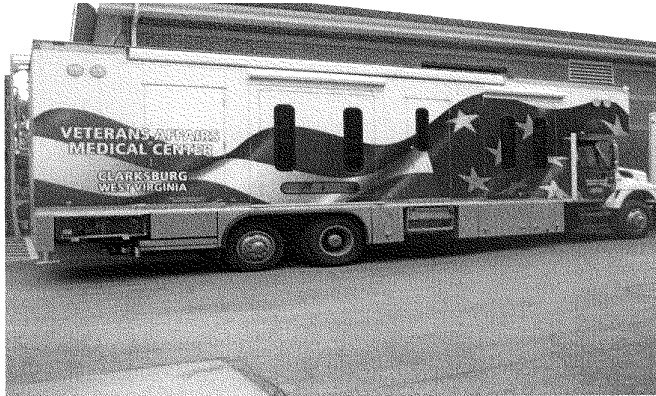
<http://www.blogs.va.gov/VAntage/wp-content/uploads/2012/01/VetCenter2.jpg>

ROA is concerned with VA's all-too-characteristic sluggishness in embracing innovation, in this case mobile health care: VA's own accounting shows that telehealth is growing. In fiscal year 2014 VA served more than 690,000 veterans through their telehealth programs, a significant increase from fiscal year 2014 when they treated 608,000 veterans through telehealth. Of this group, approximately 55 percent were for veterans living in rural areas. In 2013, Vet Centers served more than 195,900 veterans, servicemembers and military members, and provided 1,587,181 no-cost visits for readjustment counseling, military sexual trauma counseling, and bereavement counseling services.

Thematically, this points to the growth in "distributed" health care – care delivered where it's needed, often far away from a distant hospital mother ship or even a community-based outpatient clinic. VA's thousand-strong CBOC system is good, yet expensive; even as it augments VA medical centers, it can be augmented cheaply and effectively in many cases by mobile units.

According to the VA Inspector General the VA has not done as good a job using their Mobile Medical Units as they have the Mobile Vet Centers. The IG identified that some were used as little as 5 days a month.

The IG found, "VHA lacks information about the operations of its MMUs and has not collected sufficient data to determine whether MMUs improved rural veterans' health care access. VHA lacks information on the number, locations, purpose, patient workloads, and MMU operating costs."



<http://www.va.gov/oig/pubs/VAOIG-13-03213-152.pdf>

An alternative to deploying vans would be to deploy employees. VA could consider sharing agreements by placing VA employees with existing non-VA or DoD health facilities or even with clinics in department stores or drug stores. This could be done to meet care needs for more routine requirements such as, initial assessments or flu and cold season treatments. VA employees could be available in these types of facilities on a part-time basis to provide care close to where veterans live. Individuals who live in urban areas can have just as much difficulty reaching VA facilities as those that live in rural areas.

Conclusion

Delivering health care to veterans in the next 20 years must be done far better than has been done in the last 20 years. Forecasting requirements must involve considering where veterans live and are moving to as years go by, what services they will need based on service-connected versus non-service connected conditions, how technology will change care delivery, the likelihood that sheer demand for care among individuals will increase as the technology-driven availability of cure and treatment increases, and – finally and terribly – the certainty that war will provide a new generation of Veterans needing care: if the past century is at all instructive, notions of peace are illusory.

ROA appreciates the opportunity to discuss health care delivery to Veterans. We look forward to working with the commission, the Department of Veterans Affairs, and Congress to offer our support and perspective.